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ABSTRACT

The Individual Counseling Skills Training Course is a three-unit, 11-day course for alcoholism and drug counselors. One unit, dealing with individual counseling skills and client management, is presented here. The course was originally conceived for paraprofessionals in front-line counseling positions who have little or no formal academic training. It can also be adapted for homogeneous groups of professionals. The authors strongly recommend that the training be carried out in a residential setting. The format involves the use of both a trainer (who makes authoritative presentations of subject matter) and a facilitator (who uses both directive and nondirective techniques to guide the group process). Topics covered include the whole self, somatic awareness, principles of behavior change in counseling situations, and cognitive and affective closure. An accompanying resource manual for use by participants offers pretraining questionnaires, objectives, suggested activities, and additional readings. (Author/BP)

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BASIC SUBSTANCE ABUSE COUNSELOR'S TRAINING COURSE

Individual Counseling Skills
and
Client Management
Trainer's Manual

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
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PREFACE

The Division of Addiction Services, Indiana Department of Mental Health, is a combined single state authority for alcohol and drug abuse. Therefore, when feasible, training packages have been developed to train both alcoholism and drug services personnel. The Basic Substance Abuse Counselor's Training Course was designed with this in mind.

Course development began in early 1975 when the Education and Training Branch (ETB) of the Division conducted a training needs assessment of more than 200 alcoholism and drug counselors. The Division of Addiction Services employed the assistance of Social Systems, Inc., to collaborate with the Education and Training Branch staff in the design and initial delivery of this course. During the first four presentations of the course, modifications of training design were made. These were minor revisions that have been incorporated into the Trainer's Manual in its present form.

As of June 1977, nine presentations of the Basic Substance Abuse Counselor's Training Course have been delivered; a total of 220 participants have successfully completed the course.

Appreciation is expressed to H. Stephen Glenn and Joel Warner of Social Systems, Inc., for their creativeness and invaluable contribution in the development of this course.

The Education and Training Branch staff who have been involved in the development of this course are: Stanley DeKemper, Training Officer; Luz Einsiedel, Training Coordinator; Michael Ferry, Training Officer; DeRoss Salisbury, Jr., Training Officer; Robert Tyburski, Branch Chief; and Edward Ward, Evaluation Specialist.

Division of Addiction Services
June 1977

AUTHORS' NOTE

The Individual Counseling Skills Training Course is a three-unit, eleven-day course. The design of the course calls for three separate sessions to be held, one for each unit. The three sessions should be about three to four weeks apart. This allows "cooking time" for the individual to process the experience and allows time for both reading and practical application homework assignments.

The training should be residential. The advantages of residential over nonresidential training began to be heavily documented in the early 1950's, and the results are conclusive. Suffice it to say that the authors require a residential setting to conduct this course.

This course was originally conceived for paraprofessionals in front line counseling positions who have had little or no formal academic training. Experience has shown that the course can be profitably adapted for professional audiences as well. It should be noted, however, that homogeneous groups are far easier to train than heterogeneous groups. Only highly polished trainers with a high degree of ownership over the material and design should undertake the massaging necessary to train groups with highly disparate backgrounds and experience.

Finally, the group training setting is a powerful one. Trainers should respect the power of that setting and take care to manage the process and outcomes of the sessions. The trainer should be part shepherd, taking care that the flock is always accounted for. Structuring learning experiences should be done with clarity of purpose and the trainer should expect that each experience will be real and not just a game for at least some of the participants.

H. Stephen Glenn and Joel W. Warner
Social Systems, Incorporated

INDIVIDUAL COUNSELING SKILLS
UNIT B

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UNIT B : INDIVIDUAL COUNSELING SKILLS

INTRODUCTION

SOME GENERAL NOTES ON TRAINING DELIVERY

For the purpose of this course:

1. *A trainer* is a person with substantive clinical and training experience who has ownership over the structure and flow of the entire training process. This person should have charisma and enthusiasm when making presentations, and should role model openness and humility in approaching the subject matter. The trainer should be able to provide relevant examples from his own experience when necessary and should assist participants in doing the same.

2. *A facilitator* is a person with substantive small group experience who is well grounded in learning theory and skill development. This person should be thoroughly familiar with the training method of identifying, analyzing, and generalizing the significant aspects of any given training experience. This method, E-I-A-G, is used throughout the entire course. A facilitator should be competent in both nondirective and directive interaction and should model openness, trust, and humility. Because of the nature of Unit B, facilitators should have an extensive background in applied therapeutic processes.

3. *Roles* should be established and maintained in such a way that the trainer is not required to facilitate small groups and the facilitators are not required to make authorative presentations. Experience indicates that, once a person has established credibility as an authority, small groups tend to become quite directional whenever that person is present and participants ask for "right" answers instead of exploring possibilities.

4. *Materials* are designed to be used as follows: Supplementary materials are optional and appropriate substitution or supplements should be used at the discretion of the trainer. Required materials (listed by title) for each module should be utilized and presentations made which amplify and clarify core concepts in each paper.

5. *Emphasis*, throughout the course, should reflect the learning objectives for each module. As an overall set of guidelines Unit A should emphasize dependency

in a generic sense rather than substance dependence as a special case. Unit B should emphasize each counselor's attitudes, values, and behaviors and should stimulate a committment to feedback and personal growth. Further, it should emphasize an operational understanding of the Seven Principles of Building a counselor-client Relationship for Behavioral Change. Unit C should emphasize client management in helping programs including decision making, program design and teamwork in responding to individual clients.

6. *Pretests and Posttests* were developed by the Education Training Branch to measure learning (training) objectives for each component of the eleven day, three-fold training cycle. The training objectives and the pre/posttest instruments for each of components A, B, and C are included in the appropriate sections of this manual. For each component there are informational, attitudinal and behavioral objectives.

ENTRY LEVEL CHARACTERISTICS

The materials and activities contained in the individual counseling course are designed to teach participants about counseling. They have been especially compiled for persons with *little* or *no* formal academic training in counseling and an experience level of *six months* to *four years*.

Occasionally, persons with no previous experience in counseling have taken this course and although they were able to participate in the activities, their learning and retention level was greatly reduced. It is appropriate to assume that the course should be restricted to persons with a minimum of *six months* experience in counseling.

The real value of the course lies in its ability to assist the counselor in identifying significant aspects of past experience, reconceptualizing the counseling process, and obtaining feedback through observation and critique of his/her counseling skills. By their nature, such activities require an experience base in order to be effective.

THE TRAINEES' MANUAL

In cooperation with the State of Indiana, a Resource Manual has been developed by the National Drug Abuse Center for Training and Resource Development under the auspices of the National Institute of Drug Abuse for use by trainees in this course. It is very important that the trainer become familiar with the design of the Resource Manual; it follows the outline of this manual, but some of the wording has been adapted for use by the participants. In the Trainer's Manual reference is made to "handouts" -- these are now part of the Resource Manual and are called resource papers.

UNIT B: INDIVIDUAL COUNSELING SKILLS

In order to provide counselors with an opportunity to identify and assess the individual attitudes, values and behaviors which they bring to the counseling situation, Unit B provides a variety of self-assessment and practicum experiences. Emphasis is placed upn the whole person from the standpoint of mental, spiritual and physical bounds. Sociological imprints and resultant values are identified and explored.

Each participant is asked to present six aspects of his/her personal life which have relevance to counseling and explore these areas within a therapeutic setting. Priniciples of behavior change through counseling, are then introduced, and through a variety of laboratory experiences, the participants learn to identify and apply these principles in individual counseling.

Module 1, "Introduction and Assessment," provides for initial development of the training community, assists with the leveling process and encourages participants to publish and assess training needs and expectations.

Module 2, "The Whole Self," presents a view of man as a spiritual, psychological and physical being, and contrasts Eastern and Western philosophies of being.

Module 3, "Free Theatre," continues the leveling and community building activities by providing an experience in risk-taking. Participants are introduced to free theatre and non-verbally act out different emotions and states of being.

Module 4, "Somatic Awareness," is a daily exploration of body processes, including cleansing, centering, energy force fields, and flow and relaxation. Elements of yoga, meditation and neo-Reichian techniques are introduced.

Module 5, "Sociological Imprints," explores imprints resulting from differentials in gender, racial-ethnic backgrounds, age sets, socio-economic status and other life style variations. Values and perceptions resulting from these experience bases are surfaced and explored with respect to their potential influences and counseling relationships.

Module 6, "Principles of Behavior Change in Counseling Situations," presents and examines seven principles through which behavior changes. The sequential nature of these principles is explored and their value in problem solving is established. The work of major therapists is examined in light of these principles in order to demonstrate how different approaches to therapy respond, in fact, to these same principles.

Module 7, "The Six Selves," is a self-awareness learning experience designed to allow each participant to analyze the six-fold nature of his/her makeup. Emphasis is put on relating the various aspects of self to one's total makeup and applying in the counseling relationship.

Module 8, "Counseling Practicuum," provides participants with a mutual work experience on personal growth need surfaced by earlier modules. Participants receive feedback from fellow participants and trainers with respect to their counseling styles and integration of counseling principles.

Module 9, "Cognitive and Affective Closure," provides participants with an opportunity to (1) synthesize their learnings from this Unit's experience, (2) make generalizations about these learnings for implementation in their back home work situations and personal life, (3) begin the transition from Unit B to Unit C, and (4) close personal agendas with other members of the training community.

TIME REQUIRED: 5 DAYS

TRAINING GOALS To place substance abuse counseling in an operational perspective, so that the counselor will be able to:

- Recognize his/her own attitudes and values which may influence counseling outcomes
- Understand more fully the attitudes and values of others
- Understand principles of behavior change in the counseling situation
- Apply his/herself more fully as a counseling resource

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TRAINING OBJECTIVES - COMPONENT B

I. Trainee will evidence an increase in knowledge of addictions and counseling by 30 percent as indicated by a pre-post test.

   A. Given a list of potential counselor tasks and functions, the trainee will identify items which are included in the seven principles of building client-counselor relationship for bringing about client behavioral change as listed in handout #1 and #2.

   B. The trainee will be able to list and sequence a list of the seven principles of building a client-counselor relationship for bringing about client behavioral change (see previous objective reference.)

   C. The trainee will be able to define the "whole self" in terms of mental, physical physical, and spiritual balance as described by the reading handout "The Whole Self".

   D. The trainee will be able to list at least two limitations of the western or linear view of human problems according to the reading handout "The Whole Self".

   E. Given a list of human experiences, the trainee will be able to identify those which are social imprints as defined in the reading handout "Sociological Imprints".

   F. Trainee will be able to list 2 ways of using social imprints positively in a counseling situation. (see previous objective.)

   G. Given a list of terms, the trainee will identify criteria for helpful feedback as outlined by handout "Feedback".

II. Trainees will evidence a statistically significant attitudinal change in at least 2/3 of the areas listed below.

   A. Trainee will express a more positive attitude toward the significance of body awareness in the context of counseling.

   B. The trainee's attitude toward fully probing and identifying the clients pain (discomfort) is more positive.

   C. The trainee will express a feeling of increased importance of the client's acquiring new life skills.

   D. The trainee will report feeling different in accepting feedback about self.

III. Trainees will indicate an acceptable level of skill in at least 3 areas as observed by trainers.

   A. The trainee will demonstrate three methods of physical and psycho-centering as observed in somatic awareness sessions of Component B.

   B. Given a simulated client, the trainee will demonstrate the implementation of the seven principles of behavioral change in a one-to-one counseling setting. (Criteria: observations of trainers recorded on a scale.)

C. Trainee will demonstrate giving constructive feedback to peers about the implementation of the seven principles of behavioral change. (Criteria: Trainer rating on a scale.)

UNIT B:

PRETEST AND POSTTEST

PRETEST

NAME ______________________________

DATE ______________________________

BSACTP -- COMPONENT B

1. The following items are statements which a counselor might use with a client. Match each of the following items with one of the seven principles of behavior change which best describe the statement.

Seven Principles of Behavior Change

1. Establish relationship (explicit, emphathic)
2. Focus on here-and-now pain
3. Opening feedback channels
4. Formulation of problem
5. Explore options/alternatives
6. Risk/integration
7. Action plan (explore contingencies)

____ "Why are you here?"

____ "I feel that you are mad with me."

____ "What are you experiencing (feeling) now?"

____ "You seem to show strength in keeping yourself together in spite of your problem."

____ "Can you tell me exactly what you think your problem is?"

____ "Can you tell me two specific things you may want to do in place of spending Friday afternoons at the tavern?"

____ "If your wife will not believe that you are no longer drinking, what will you do about it?"

____ "How will I know that you are being honest to yourself and our contract?"

2. Define the "whole self" in terms of its three component parts.

3. List two limitations of the western or linear view of human problems.

1.

2.

4. Of the following list, check the items which can be identified as social imprints.

____ Abstinence is a popular alternative to addiction.

____ Children should be seen and not heard.

____ Never admit your mistakes.

____ My daughter is a good mother.

____ A woman's place is in the home.

____ I often feel I am in error.

5. Name two reasons why social imprints are important in a counseling relationship.

1.

2.

6. From the following list, check the items which are criteria for helpful feedback.

____ Evaluative rather than descriptive.

____ Well-timed.

____ General rather than specific.

____ Solicited.

____ Checked for accuracy of communication.

7. I am comfortable accepting feedback about myself which may indicate a need for me to change.

agree |—|—|—|—|—|—|—| disagree

8. Acquiring new life skills is not the ultimate reason for clients being counseled.

agree |—|—|—|—|—|—|—| disagree

9. I feel that probing the clients painful or uncomfortable areas of life is not important to the therapeutic process.

agree |—|—|—|—|—|—|—| disagree

10. I am aware of my own physiological reactions in various situations.

agree |—|—|—|—|—|—|—| disagree

11. I am aware of physical reactions of my clients during counseling sessions.

agree |—|—|—|—|—|—|—| disagree

POSTTEST
PART ONE

NAME________
DATE________

BSACTP -- COMPONENT B

1. List in order the seven principles of behavior change.

   a.

   b.

   c.

   d.

   e.

   f.

   g.

POSTTEST NAME ______________________

PART TWO DATE ______________________

BSACTP -- COMPONENT B

1. The following items are statements which a counselor might use with a client. Match each of the following items with one of the seven principles of behavior change which best describe the statement.

Seven Principles of Behavior Change

1. Establish relationship (explicit, emphathic)
2. Focus on here-and-now pain
3. Opening feedback channels
4. Formulation of problem
5. Explore options/alternatives
6. Risk/integration
7. Action plan (explore contingencies)

____ "Why are you here?"

____ "I feel that you are mad with me."

____ "What are you experiencing (feeling) now?"

____ "You seem to show strength in keeping yourself together in spite of your problem."

____ "Can you tell me exactly what you think your problem is?"

____ "Can you tell me two specific things you may want to do in place of spending Friday afternoons at the tavern?"

____ "If your wife will not believe that you are no longer drinking, what will you do about it?"

____ "How will I know that you are being honest to yourself and our contract?"

2. Define the "whole self" in terms of its three component parts.

3. List two limitations of the western or linear view of human problems.

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4. Of the following list, check the items which can be identified as social imprints.

____ Abstinence is a popular alternative to addiction.

____ Children should be seen and not heard.

____ Never admit your mistakes.

____ My daughter is a good mother.

____ A woman's place is in the home.

____ I often feel I am in error.

5. Name two reasons why social imprints are important in a counseling relationship.

1.

2.

6. From the following list, check the items which are criteria for helpful feedback.

____ Evaluative rather than descriptive.

____ Well-timed.

____ General rather than specific.

____ Solicited.

____ Checked for accuracy of communication.

7. I am comfortable accepting feedback about myself which may indicate a need for me to change.

agree |—|—|—|—|—|—|—| disagree

8. Acquiring new life skills is not the ultimate reason for clients being counseled.

agree |—|—|—|—|—|—|—| disagree

9. I feel that probing the clients painful or uncomfortable areas of life is not important to the therapeutic process.

agree |—|—|—|—|—|—|—| disagree

10. I am aware of my own physiological reactions in various situations.

agree |—|—|—|—|—|—|—| disagree

11. I am aware of physical reactions of my clients during counseling sessions.

agree |—|—|—|—|—|—|—| disagree

MODULE 1 : INTRODUCTION AND ASSESSMENT

MODULE 1: INTRODUCTION AND ASSESSMENT

Focus, Objectives and Resources

FOCUS

Module 1 establishes the framework for subsequent modules in Unit B. It is intended to stimulate discussion among participants and elicit concerns regarding personal growth and counseling principles.

A process for interviewing and introducing participants will be established. Participants will identify their most pressing concerns about individual counseling and will share these concerns with other members of the training community. Small groups of participants will compile abbreviated lists of concerns to be presented to the training community.

Participants will interview a partner in dyads both verbally and non-verbally to begin the process of looking at the whole person and at oneself in the process.

LEARNING OBJECTIVES

Upon completion of the activities in this module, the participant will be able to:

- Share some personal impressions of a fellow participant with the training community.
- Identify at leaset one personal concern about counseling.
- Express the concern of at least one other person in the training community.

RESOURCES REQUIRED

The learning activities in this module require:

- A flip chart and six felt tip pens
- A large room with flexible seating
- Masking tape
- Space for four to six small groups
- A Trainer
- Pencils and questionnaires for each participant

MODULE 1: INTRODUCTION AND ASSESSMENT

Learning Activity Schedule

Activity 1
30 Minutes

Pre-Test

Briefly explain the purpose of the pre-test to measure the group movement for training evaluation.

RESOURCES REQUIRED

- Lead trainer or cycle manager
- Pencils
- One copy of the pre-test instrument for each participant.

Activity 2
30 Minutes

Participant Welcome and Orientation

Briefly welcome the participants, energizing them if necessary. If this training follows Unit A (the fundamental facts and in insights course), explain the changes in the learning process from Unit A to Unit B, encouraging trainees to risk self-disclosure and give honest feedback. Challenge them to take full responsibility for their personal growth goals and counselor-skill goals.

This should be followed by a brief review of the flow of training events in Units A, B, and C and an overview of the content of Unit B.

RESOURCES REQUIRED

- A lead trainer or cycle manager
- A large room with flexible seating
- A flip chart
- Masking tape
- Felt pens
- A reference copy of this manual.

Activity 3
1 Hour and
45 Minutes

Assessment

Each participant fills out a pre-training questionnaire. Dyads are formed and participants exchange their responses to items one through six on the questionnaire. Small groups of six to eight participants are formed and each person introduces his/her partner by explaining the partner's response to item four. Each group is assigned to pick a spokesperson and negotiate a list of three or four questions which it can recommend for consideration to the entire training community. The groups then reports back to the community.

RESOURCES REQUIRED

- Newsprint and felt tip pens for each group
- Pencils and questionnaires for each participant
- A trainer
- Space for six to eight small groups
- Masking tape

Activity 4
1 Hour
15 Minutes

Participants are divided into 2 groups of about 12 persons and form dyads to interview each other, at first verbally, then non-verbally. Emphasis should be placed on attitudes, values and data which is non-demographic. At the conclusion of the interview, participants form a large circle and introduce their partners to the training community in the first person singular. This experience is processed in 3 groups of 6-8.

RESOURCES REQUIRED

- A large room with flexible seating
- Two lead trainers
- Small group rooms or work areas

MODULE 1: INTRODUCTION AND ASSESSMENT

Trainer Guidelines

Activity 1
30 Minutes

Make a brief presentation designed to set participants at ease about the pre-test.

Activity 2
30 Minutes

The trainer will make a brief presentation designed to set the participants at ease and give them a sense of the flow and order of the training activities.

Emphasize that Unit A (the Basic Substance Abuse Counselor's Training Program -- a fundamental facts and insights course) described what needs to be done and that Unit B begins to focus on how it is to be done. This "how to" aspect of Unit B revolves around the role and function of the counselor in the individual setting and his/her abilities to achieve the necessary therapeutic goals. Fulfilling these roles and functions involves two training thrusts for the trainee (1) personal growth in self-awareness and (2) learning the skills of managing (building) a client-counselor relationship for behavioral change.

A review of the learning goals of all three units of the course is necessary preparation for exposing the participants to the place of Unit B in the flow of the total course. Provide the participants with a sense of purpose for approaching each activity and help to build a sense of committment and involvement to the process.

Activity 3
1 Hour 45 Minutes

Instruct the participants to conduct a self-assessment by answering in writing the pre-training questionnaire. After this, instruct them to pair off with another participant whom they do not know well or whom they perceive as being most different from themselves. They should discuss their question responses thoroughly enough so that each person can reflect his/her partner's response in his/her own words. The rationale for doing this is to illustrate the difficulty in correctly interpreting another person's concern and to provide an opportunity to refine and clarify one's own concern.

While putting the parcicipants into groups of three or four pairs, instruct them to introduce to the group both the partner and the partner's response to question four of the Pre-Training Questionnaire: "What specific experience would you like to occur in these five days?" After sharing all the questions, each group is then to negotiate a list of questions. The number of questions should be equal to one-half the number of people in the group. The questions should be those which the group can recommend to the entire community for consideration. These questions are printed on newsprint and a spokesperson is chosen to report the questions to the community. The lists of questions should be taped to the wall and displayed throughout the training. Each group should facilitate itself, but the trainer should moniter the time and progress. A trainer with comments from other staff responds to the questions presented in terms of how they will be dealt with in the training, noting honestly if certain questions cannot be addressed.

Activity 4
1 Hour 15
Minutes

All staff should participate. Divide the training community in half, about 12 persons to a section. Within each section, a lead trainer instructs the participants to pair themselves with a person wh-om they did not get to know well during Unit A or whom they perceive as being most different from themselves. Ask them to interview one another, focusing the interview on personal aspects of the individual, deemphasizing statistics and concentrating on such things as what things the person does for enjoyment, his/her hopes, values -- what the person expects from training, how leisure time is spent, etc.

After about 20 minutes, ten minutes for each member of the pair, instruct the dyads to continue the interview non-verbally. Encourage each to explore the other's body thoroughly noting areas of perceived tension. Ask each one to make a mental note his his own feelings during the non-verbal experience. The non-verbal portion of the interview should last about three to four minutes.

The lead trainer should be the first to introduce his/her partner. This is done by standing behind the partner and placing the hands on the partner's shoulders in a comfortable and relaxed position, all the while verbalizing these instructions. Introductions then proceed around the circle. Participants should be given the opportunity to share their feelings and impressions of the experience.

MODULE 1: INTRODUCTION AND ASSESSMENT

BASIC COUNSELORS TRAINING - COMPONENT B
PRE-TRAINING QUESTIONS

1. Why are you attending this workshop?

2. What do you personally hope to accomplish to attending?

3. What specific skills or new behavior do you wish to develop?

4. What specific experiences would you like to occur in these five days?

5. Is there anything you specifically do not wish to happen in these five days?

6. Additional comments:

MODULE 2 : THE WHOLE SELF

MODULE 2: THE WHOLE SELF

Focus, Objectives & Resources

FOCUS

This discussion presents the concepts of the three fold nature of man, emphasizing the importance of this notion to the counseling situation. The spiritual, physical and mental aspects of the individual are considered, together with the interrelationships between these aspects.

During this presentation, the classical Eastern and Western theories of the individual are compared and contrasted, and the various implications for counseling are discussed. During this process the participants have the opportunity to examine their own ontological assumptions and the role they play in determining their own stance and style as a counselor.

LEARNING OBJECTIVES

At the conclusion of this module, the trainees will will be able to:

- Explain the concept of mental, physical and spiritual balance.
- Name two limitations in the Western or linear view of human problems.
- List three advantages of approaching clients from the perspective of the "Whole person".

RESOURCES REQUIRED

The learning activities in this module will require:

- A trainer
- A large room
- A flip chart and felt tip pens
- A facilitator for each eight participants
- A small group room for each facilitator

MODULE 2: THE WHOLE SELF

Learning Activity Schedule

Activity 1
1 Hour

Trainer Presentation

The trainer presents the material on the wholistic approach to counseling as outlined in the resource material. The emphasis is on the relationships between counseling strategies and the view the counselor hold of an individual *qua* individual. The implications of various ontologies, notably Eastern versus Western, is examined in operational terms.

RESOURCES REQUIRED

- A trainer
- A large room
- A copy of the resource paper for each participant

Activity 2
1 Hour

Discussion Group

The implications of the wholistic approach to counseling should be discussed sufficiently so that each participant has the opportunity to internalize the ideas and feelings he/she has about the materials.

RESOURCES REQUIRED

- A facilitator for each eight participants
- A small room for each facilitator

MODULE 2: THE WHOLE SELF

Trainer Guidelines

Activity 1
1 Hour

Much care should be taken to communicate the material in this section to the participants. The trainer should avoid using language and ideas foreign to the participants and assume the burden of communication. A review of the materials and learning objectives for this module will provide the trainer with an understanding of the scope and purposes of this module. The presentation should answer the purposes of the module while adapting the material to the group. The trainer should avoid philosophical divergences which could lead to frustration on the part of the participants.

The trainer should bear in mind that the objective of this module is to surface the issue of the role a counselor's ontology plays in his/her approach to clients. By offering alternative formulations to traditional Western views of man, and by outlining the implications these views have for counseling, the trainer can most effectively expose the participants to other formulations to the end of demonstrating techniques and approaches a counselor can use to benefit the client.

Activity 2
1 Hour

Divide the large group into smaller groups of approximately eight individuals. The groups should be divided in such a way as to provide for maximum cross-sectionality.

Assign a facilitator to each group and move to a small group space. Each facilitator leads a discussion of the presentation made in the large group, asks questions to stimulate partcipants to examine and share their own experience with respect to the presentation and makes certain each participant has the opportunity to identify, analyze, and generalize significant aspects of the experience. (This last aspect of the training is called EIAG, and shall be referred to as such hereafter.)

THE WHOLE SELF

by

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Prepared

by

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THE WHOLE SELF

The whole self involves an examination of the way we perceive human beings (both ourselves and others). We have all heard the expression "I can't see the forest for all the trees." It refers to a misperception resulting from focusing on a specific part at the expense of the total picture. This corresponds to our perception of the self in comparison to the whole self-concept. We have been focusing on a limited view of the self at the expense of the total picture of the individual. I want to examine our present perceptions, change our focus and look at the whole self, and examine the implications each way of perceiving has for the client/counselor relationship.

The way a society perceives something is reflected in the language it uses (or invents) to describe it and the institutions it sets up for relating to it. For example, a society that did not perceive "love" would have no words for it and no institutions (marriage, courtship) to deal with it. Not only are our perceptions reflected in the language and institutions we invent, but they are passed on from one generation to another through our language and institutions.

Our perception of people who steal from other people is partially influenced by the way our ancestors described them (thieves, crooks, hoodlums) and by the institutions set up to deal with them (court, jail, prison). Since our ancestors deemed it necessary to set these people apart in language and in reality (jail) we learn to perceive people who steal as a threat. Unfortunately, we set many groups apart in language (Negro, alcoholic) and reality (ghetto, treatment program) and communicate to our children the perception that these people are different, undesirable and threatening.

How do our language and our structures reflect and shape our perceptions of the individual?

In a Western industrial society like the United States, our perceptions of the individual are reflected in and shaped by:

(a) our classification of people according to function (lawyer, housewife, client, counselor);

(b) our tendency to describe people according to obvious physical characteristics (black man, young girl); and

(c) our tendency to rate (judge) people (including ourselves) according to a few either/or standards (good boy/bad boy, pretty girl/unattractive girl, saint/sinner, smart/dumb, success/failure, O.K./not O.K., winner/loser).

Let's look at how each of these affects the way we perceive the individual.

Our classification of human beings according to function is reflected in our emphasis on careers and our increasingly specialized jobs. While this specialization has benefits for mass production, it narrows our focus from the whole self to one small part of the individual. We even tend to define ourselves by our profession (counselor) while ignoring many vital aspects of our lives (husband, father, Catholic, athlete, friend, neighbor, citizen, etc.) that contribute to the whole self.

Our description of people according to obvious physical characteristics also limits our perception of individuals. While it is convenient to classify people according to obvious physical and behavioral characteristics in our busy, mobile, individualized society, it shifts our focus away from the complex whole person to a specific trait of the person that is easy to classify. This also allows us to make generalizations about a person (she is pretty, therefore ...) without bothering to know that person as a human being. This emphasis on the superficial and the obvious may lead a person to believe that the image he projects is all that is important. This narrows his focus on himself from a complex, multifaceted creature to a person who defines himself by the way others react to him.

The tendency of Western society to rate (judge) people according to ill-defined either/or standards

"Good girls don't ..."

"Christians do ..."

"Big boys don't ..."

sets up unrealistic expectations of ourselves and others. By setting up such standards we are making our acceptance of ourselves and others conditional on attaining a certain goal or on not making any mistakes. We are again narrowing our focus on the self to one area and letting our approval or disapproval of the person hinge on success or failure in this narrow area. It also communicates the message that a person isn't complete until he achieves some success in a particular area. We focus on what we aren't rather than what we are. The whole self involves widening our awareness to focus on all the things we already are.

Now let us change our focus to look briefly at a more primitive, integrated society with an Eastern view of the self. Remember, this is a totally integrated society where all the members contribute to fulfilling one anothers' physical, mental, and spiritual needs. It is something like the extended family. Here the individual is not categorized in terms of function because all functions are shared by all members of society. Each task is viewed as equally important to the functioning of society. Nor are individuals categorized by obvious physical characteristics. In an integrated tribal or communal society each person can be known individually and there is no need to categorize. Many American Indian tribes never state the obvious in their conversation so the individual is not perceived, by himself or by others, as just a lawyer, or a hunter, or a housewife, or a tall man, or a pretty girl. The "Eastern" society encourages each individual to include the vast array of physical, mental, and spiritual functions when defining his concept of himself and his concept of others, because all these functions are integrated, not separated, within the society. The individual is a reflection of the society that fosters him. He is a totally integrated individual with all aspects of his "self" contributing to his perception of the "self." Each aspect of the self is viewed as equally important to the functioning of his society. Moreover, with so many aspects of the self included in the self-concept it is impossible to judge the individual for a failure to achieve in any one area. The society isn't dismissed because of a failure in one area and neither is the individual. The focus is on what the individual is, not what he is not or should be.

Obviously, we cannot all participate in an ideal tribal society, but the comparison between the Eastern and Western views of the individual brings up some important considerations for counselors. Helping our clients understand their behavior and recognize their problems requires someone with a broad perspective of the individual. Since we have grown up with the Western perception of the individual that tends to categorize and judge, our perceptions of our clients and ourselves may be limited.

Western Society separates the mind, body, and spirit. We have separate institutions for each component (mind--schools, mental health centers; body--health spas, sports; spirit--church). We turn to different specialists to help us with problems in each area (mind--psychologist; body--doctor; spirit--minister). In fact, we even set aside specific segments of time for dealing with our spiritual self (Sunday morning) and physical self (weekend sports, bedtime, sex at a specific time) while we ignore these integral aspects of the self the rest of the week. Similarly we often deny our own mental health needs and keep our problems inside (which makes them seem gigantic and unmanageable) rather than admitting these problems and dealing with them openly (which makes them smaller and more manageable). We only acknowledge the needs of our mind, body, and spirit when it is appropriate to acknowledge them. We let the Western idea of appropriate/inappropriate, right/wrong, good/bad, tell us when (if ever) it is permissible to talk about or even be aware of entire parts of ourselves. By shutting awareness of the mind, body, and/or spirit because certain thoughts, feelings, and actions are socially unacceptable, we are keeping ourselves from knowing ourselves. We are denying our own needs in order to live up to the expectations others have for us. In effect, we are living for the image we project not for ourselves.

For example, I find that it is much easier to share myself in an accepting environment like training than in most other situations. At training, I feel free to get in touch with the various aspects of myself that I have learned to ignore on the job and in less accepting social situations. In a caring community like training, I can share what is on my mind (hopes, worries, confusion) without worrying what others will think. Moreover, I know that sharing what is on my mind will give me useful feedback about my mind and how it works and I will grow through self-understanding.

Similarly, I feel free at training to explore my spiritual self. I can bring my spiritual questions, beliefs, doubts, fears, and longings out in the open and learn how the spirit manifests itself in me and in others. This brings my spiritual self into clearer focus and increases my awareness of my spiritual self. In the nonjudgmental, nonlabeling atmosphere of training I can get beyond the shallowness of ill-defined labels like believer/atheist and beyond the rigidity of maxims like "Christians should..." and really begin to explore my spirituality.

This nonjudgmental atmosphere also increases my awareness of my body and the messages it sends me. Our bodies are constantly sending us messages. My body tells me when I am too warm or cold, when I need to urinate or defecate, when I am hungry or thirsty, when I am sexually aroused, when I am sleepy, and when I am in pain. However, I have learned to ignore many of these messages in my daily life. For example, I often ignore messages of pain from my body because pain is not comfortable. I learn to suppress my hunger pangs until lunch when I can deal with them. I may suppress messages such as sexual arrousal because there is not a socially acceptable way of dealing with the feeling at the time. By denying socially unacceptable or uncomfortable signals from my body I develop a pattern of ignoring a part of myself. I let my mind censor the messages from my body thereby cutting off awareness of a part of myself. After spending a week in the nonjudgmental, accepting atmosphere of training, I am more in touch with the messages by body sends me. For instance, at the beginning of a week of training I tend to overeat. My eyes are bigger than my stomach. At the end of the week I seldom overeat. The channels of communication between my mind and body seem to be open and I am in better touch with my appetite. My eyes are no longer bigger than my stomach.

In training, as in Eastern tribal society, the emphasis is on exploring, learning, and becoming aware. The Western concepts of getting the "right" answer, competing for grades, and performing to meet others' expectations do not apply. In training I feel free to learn who I am, not who I "should be." I become more aware of my mind, my body, and my spirit, and this increased awareness itself has healing qualities. I feel more whole and balanced and I begin to understand that ignoring my mind, body, or spirit is fragmenting in that it closes off intrapersonal communication channels and prevents me from knowing myself and recognizing my own needs. Moreover, this fragmentation throws the entire system out of balance as unrecognized needs remain unmet and the resulting tension affects other parts of the self. Unrecognized hunger needs, for example, remain unmet and can make us cranky and irritable. By staying in touch with hunger, we may not be able to satisfy our hunger immediately, but the awareness of the hunger can help us recognize where our irritability originates and find more suitable ways of dealing with it than yelling at our families.

Our clients also need a safe nonthreatening place to explore themselves and their unrecognized needs. It is our job as counselors to provide a nonjudgmental atmosphere where the emphasis is on exploring, growing, and learning. Rather than molding our clients into a preconceived ideal that further fragments human beings by telling them what they should be, we must encourage our clients to grow by exploring and becoming aware of all aspects of themselves rather than one narrow aspect like their image or their alcoholism. We must help each client focus on the forest rather than the trees and find the healing, nurturing parts of himself that can help him discover the healthy, balanced, whole human being beyond his fragmented self.

MODULE 3 : FREE THEATRE

MODULE 3: FREE THEATRE

Focus, Objectives & Resources

FOCUS

"Free Theatre" is an exercise in centering, risk-training and non-verbal communication. By participating in the Free Theatre, the training community will come closer together and feel more of the unity necessary for personal growth activities which will occur during the week. By experiencing the non-verbal expression of emotions, the participant will be better able to perceive the significance of non-verbal expressions on the part of the clients.

This activity is the final formalized leveling activity although informal leveling of the training community is an ongoing process. Other formalized leveling activities can be undertaken throughout the training experience if needed.

LEARNING OBJECTIVES

At the conclusion of Module 3, each participant will be able to:

- Identify two feelings which he/she experienced in responding non-verbally to acting out feeing words and acting our roles.
- Identify which role acted our was most comfortable which was least comfortable.

The activities in Module 3 will require:

- A large room
- A trainer
- A facilitator for each eight persons
- A small room for each facilitator
- A list of pairs or opposite emotions and a list of pairs of opposite roles
- Pencils
- Paper

MODULE 3: FREE THEATRE

Learning Activity Schedule

Activity 1
1 1/2 Hours

Free Theatre

In a large room the participants are lined up, half along two opposite walls. The lead trainer instructs the participants to be completely non-verbal during the experience. He offers one half of the group an emotion word such as "joy"; the other half an opposting word such as "anger", asking them to non-verbally act-out the emotion assigned. After two to three minutes, the assignments are reversed. Three to four pairs of word-opposites are acted out.

After it appears, that the participants, are warmed-up to the experience, one half of the group is given a role such as "nice guy"; the other an opposite role such as "bully" and asked to act out the roles non-verbally for two to three minutes. Immediately on stopping each person, without talking, is asked to identify one or two strong feelings he/she experienced during the acting and to write them down on paper against the role played.

The roles are reversed and the feelings written down again. This process is continued through three or four more pairs of roles, writing down the felt feelings after acting out each one.

Finally, each participant is asked to reflect on his/her experience studying his/her notes and select the role which was the favorite and the role in which he/she felt most discomfort. After a few moments, ask the group to act out the favored roles; then the most uncomfortable roles, writing down the feelings felt this second time and comparing them with the first.

The lead trainer should allow the group to ventilate spontaneously about the experience for a few minutes. The participants are then assigned to their Static Groups to process this experience and those of Modules 1 and 2 in depth.

RESOURCES REQUIRED

- A lead trainer
- A large room cleared for ample floor space for each member of the community to freely move about simultaneously.
- Pencils and paper
- A list of pairs of opposite emotions
- A list of pairs of opposite roles

Activity 2
1 Hour
(longer at
group option)

Static Groups

The static group meets daily throughout the training, especially for an hour or more at the conclusion of each day's activities. Its purpose is to provide for continuity in training and to develop a supportive atmosphere in which personal concerns can be expressed and worked on. The facilitators of the static groups should be persons well versed in individual counseling skills as well as facilitation *per se*.

The static groups will be the vehicle used for the self-awareness and growth providing experiences. In these sessions the individual participants will work on feelings surfaced in laboratory or practicum experiences and resolve dissonance which may be raised.

Conceptual integration of the material presented throughout the training session shall be an ongoing task of the static group.

RESOURCES
REQUIRED

- A facilitator for each six to eight participants
- A small room for each facilitator

MODULE 3: FREE THEATRE

Trainer Guidelines

Activity 1
1½ Hours

The training community should be divided into two groups, who will alternately take the observers and the active roles. Designate group roles and move the observers to the outside perimeters of the room, leaving a lot of room for the group taking the active role. Call out a pair of emotions which are opposite in nature (e.g. "angry-please") and give each dyad about ten seconds to decide on dividing the emotions. (As an alternative, the members of the dyads can do the first-mentioned emotion, and number two would do the second. With this procedure the order of the emotions should be varied so as to vary the roles of the individuals in the group.)

Each set of emotions should be acted out non-verbally, with participants free to move around the room at will. When each set of emotions has been allowed to run a reasonable amount of time (usually 1-3 minutes, or until all have participated well), call out another set of emotions. This should continue through five or six sets, at which time the observer group has the opportunity to comment upon what it observed.

When the observer group has offered its comments, those in the active group should express how they felt throughout the experience. This accomplished, the roles of the two groups should be reversed and the process repeated.

Activity 2
1 Hour
(longer at
group option)

In small groups the participants should have the opportunity to discuss the nature of the experience they have had. Care should be taken to focus on the relevance which the participants see that this experience has for counseling. Each participant should have the opportunity to EIAG the experience.

The static groups should be comprised of no more than eight participants. Each group should be constituted in such a way as to provide a support base for each participant. Wherever possible persons from the same agency, husband and wife, etc., should not be in the same static group.

Within the static group, the individual participants must have the opportunity to resolve dissonance in a producive way. The activities and structured learning experiences which they will participate in are designed to elicit feedback, promote self-awareness and expose the individual to a manageable amount of personal risk. The facilitator must see that all such experiences, many of which may involve pain, culminate in a productive resolution for the individual. In this way, the facilitator-therapist, through the vehicle of the static group, can promote change and growth.

The major tool available to the facilitator-therapist is the EIAG model of facilitation. The EIAG model, simply stated, requires that each experience, if it is to be a productive learning experience, be discussed is such a way that each participant goes through the following steps:

- Identification of the elements of the experience which were significant to the individual.
- An Analysis of why those elements were significant and how they came to be significant for the person.
- A Generalization or application of the learning from the particular experience to the person's life as a whole.

Inasmuch as the focus of the present course is individual counseling skills, the static group should focus on this. When individuals have problems or business to work on, that person and a volunteer should move within the circle and work on a one-to-one basis. Others can observe and give feedback on the session after its conclusion. In this way the static group should not be used as a group counseling session.

To bring final closure to the days activities, static groups will meet for whatever amount of time is necessary to bring affective and cognitive closure to the day. It is anticipated that this will take about one hour in most instances.

MODULE 4: SOMATIC AWARENESS

Focus, Objectives and Resources

FOCUS

The somatic awareness portion of the training is to bring the physical, spiritual and mental elements of the training into harmony. These activities are based on Eastern philosophies and practices and on Reichian and Neo-Reichian theories of body processes and their relation to spiritual and mental health.

Elementary aspects of yoga, meditation and breathing excercises are brought into focus as both methods of personal centering and cleansing for the participants and as therapeutic techniques. Participatory in nature, this experience is structured in such a way as to allow the participants every opportunity to realize the full impact of these processes.

LEARNING OBJECTIVES

At the conclusion of Module 4, each participant will be able to:

- State the importance of body awareness in the counseling context.
- Demonstrate three methods of physical and psycho centering.
- Explain two ways to assist clients through the rise of somatic techniques.

RESOURCES REQUIRED

The learning activities in this module will require:

- A large carpeted space or large lawn
- A trainer versed in somatic techniques

MODULE 4 : SOMATIC AWARENESS

MODULE 4: SOMATIC AWARENESS

Learning Activity Schedule

Activity 1
30 Minutes

Somatic Processes

The participants will enact several types of yoga, meditation, breathing, energy flow, etc., activities. While these are being tried, the trainer will explain the origin, use and possible application of these techniques both to the participant's personal life and to the counseling situation.

RESOURCES REQUIRED

- o A large carpeted space or large lawn
- o A trainer versed in somatic techniques

Activity 2
15 Minutes

Discussion Group

The participants will discuss their experiences in this module and explore any feelings, impressions, or ideas which they had which seem appropriate to discuss.

RESOURCES REQUIRED

- o A trainer
- o A large carpeted space or large lawn

MODULE 4: SOMATIC AWARENESS

Trainer Guidelines

Activity 1

Each morning prior to breakfast, the participants have the opportunity to experience some of the somatic techniques which characterize the work in bioenergetics and Eastern mysticism. The work in this area should parallel the philosophies discussed in Module 2, "The Whole Self." Correlating the activities in this module with the conceptual work of Module 2, will assist in the conceptual integration of the experience and thus assist the participants in making the step to appropriate application of the techniques.

There are no specific instructions as to procedures here, as much will depend on the experience of the trainer and the type of group attending the training. This module must be handled by someone with a solid background in the area, and must not be done on an experimental basis.

There are often advantages to working outside if the weather and situation is favorable.

Activity 2

As the experimental portion of the module comes to an end, it is essential that there is a discussion of the experience. The trainer has the obligation to bring closure to the module. This entails not only the EIAG process which is essential for tying the experience to the training and for practical application beyond training, but there is also the possibility of surfacing questions, emotions, anxieties, etc., which must be resolved prior to completion of the activity.

BODY AWARENESS AND SUBSTANCE ABUSE COUNSELING:
AN INTRODUCTION

by

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BODY AWARENESS AND SUBSTANCE ABUSE COUNSELING: AN INTRODUCTION

In recent years, one of the emerging trends in the counseling profession has been the utilization of the human body as a diagnostic tool and as a therapeutic focus. Numerous articles, books, abstracts, and other literature have been produced which relate the significance of body awareness and manipulation as a means of preventing and curing the pain prevalent in our everyday experience. Paperback books about yoga and body language proliferate at our corner drugstore newsstands. Medical journals and scientific abstracts now include the same topics. Even American Airlines features articles on yoga and tension release in its monthly magazine for passengers.

Previous to this recent tidal wave of attention to the human body, the only people seen as qualified body technicians were doctors, nurses, and physical therapists. The Age of Specialization was very provincial and was not integrated: mental health professionals worked with the mind and physicians focused on the physical. Today, the concept of the whole person is being revived and is evidenced by a greater percentage of medical students going into family practice and by therapists who now explore a client's diet, exercise habits, and physical health as well as his mind and emotions. Growing validity is being given to the belief that psychological processes (as well as spiritual) are expressed in and by our bodies. Doctors are now estimating that 60-70% of all their patients have psychosomatic illnesses.

Helping professionals, from doctors to ex-addict/recovering alcoholic counselors, are now devoting more energy and time to developing an understanding of how our body, mind, and spirit are all interrelated and interdependent. Through research and through personal experience we are discovering that our bodies, minds, spirits, feelings, interactions, and behavior are all manifestations of our true essence.

In this paper, I would like to explore the concept of body or somatic awareness as a means for understanding and helping dependent people. This concept of somatic awareness revolves primarily around the assumption that if I have complete knowledge of myself, I can then choose to be the "way I want to be."

One obvious and real way to gain complete knowledge of myself is to be aware of everything I do and the way I am. I am the words I talk. I am my farts. I am the tension in my neck. I am my posture when I talk to a woman. I am the person who takes a drink of J & B Scotch before I talk to anyone. To be aware of my behavior and my total self is a prerequisite for controlling my own life.

PRIMARY CONCEPTS OF SOMATIC AWARENESS

Although there are many, many techniques and approaches to somatic awareness, there are five primary concepts which are more or less common to most somatic approaches. These five concepts are: Breathing, Centering, Grounding, Deep Relaxation, and Energy Flow.

It is important to remember that when we focus our awareness on our body that the mind is the information processor for our awareness as well as being another part of our body. Thus, the mind is an integral part of the somatic awareness process. The key to somatic awareness is to allow the mind to receive unfiltered messages from the body. The instant we begin to explain or justify these messages we lose their meaning. It is also important to know the situation which surrounds a certain message or sensation. It is significant to be aware that my breathing becomes shallow and rapid *when* I talk to a woman *because* I was weened at an early age, etc. *Awareness* does *not* need a *why* or *because*. Thus, as I explore the five primary concepts of somatic awareness, keep the function of the mind in your conscious as you conceptualize somatic awareness.

Breath

Of all our body processes, breath is the only one which can either be controlled or automatic. Breath is a part of both our conscious and our unconscious. It is connected to our deepest feelings as well as our minds. We all (I hope) have experienced a panting as we become sexually aroused or held our breaths as we narrowly missed having an auto wreck. These are both examples of breath hooked to our deepest feelings. And yet we can focus on our breath and breathe the way we want.

Breath is seemingly easy to control. Yet the average person gives up conscious control of breath to his autonomic nervous system and goes through life without controlling his breath. Our breath brings in more energy and nourishment and expels more toxins than any other body process. Yet how many of us allow as much daily consciousness to breathing as we do to eating, urinating, defecating, and sweating?

Focus on and awareness of breath can help us gain control over our emotions. Neurotics and psychotics have definite breathing patterns. Each of us also has a breathing pattern. Knowing our pattern can help us see when and how we block our energy and potential. If I feel nervous, I can focus on my breath, realize I am breathing shallowly and in my throat, breathe deeply from my belly and feel more relaxed.

Breath is a two-way street. It can facilitate awareness of our feelings and unconscious as well as give us control over our emotions.

Centering

One trait which is overwhelmingly common to people who depend on substances is a feeling of being overrun or being controlled by outside influences. This is often manifested by over concern with "what others will think," with "shoulds" or "ought to's," or with having a room arranged the "right way." Most of our clients center themselves in their environment; on other people or on significant material objects.

Somatic centering concentrates on enabling us to focus on our natural or physical center. This center is located near our navels. When we are focused there we are in better contact with our feelings and desires. When we come from there or know what is there, we experience more power.

If I am not focused at my natural center, I will be off balance. My muscles will have to strain to hold up my body instead of allowing my skeleton to support me. Energy and power will be diverted from achieving my goals to holding up my body. By using various centering techniques we can go within ourselves, know our own feelings and desires, and not waste energy supporting our out-of-balance bodies, trying to manipulate our environment or trying to meet the expectations or values of others.

Grounding

As a culture and civilization, we are very rational, conceptual, and head oriented. We spend the majority of our time thinking, looking, and talking. We don't spend much time doing or feeling. We watch people being killed on T.V. shows or the news. We will talk about it, but we usually don't do anything to stop it or don't cry or vomit at the sight of it. Most of us talk about sex, think about it, or watch it on T.V. Yet, most of us have sex only once or twice a week. Dinosaurs became extinct when their brains became too small for their enormous bodies. Will we too destroy ourselves by staying in our heads and fantasies and allowing our bodies to degenerate?

Grounding focuses on helping a person gain contact with physical reality, to stand on their own two feet. If we understand the pain and pleasure of physical existence, we can use that grounding to balance our ideas and our dreams.

Deep Relaxation

Historically, deep relaxation has been used for ages as a therapy tool and as a means to control tension. Developed in the West by Mesmer, deep relaxation is often kept under control of the therapist, especially if deep hypnosis is employed. In the context of somatic awareness, deep relaxation can be safely used by us and our clients as a means of taking responsibility for ourselves.

Deep relaxation is based on the assumption that most of us seldom fully relax. Operationally, it involves experiencing tension, then experiencing relaxation, and finally developing an awareness of the accompanying feelings. Once we are aware of what tension feels like and of what relaxation feels like, we can then begin to control ourselves when we are tense by consciously relaxing the tense parts of ourselves.

Many of our clients use substances to block tension or to reduce it. We all know that alcohol loosens us up, don't we? Deep relaxation allows us to take control over our tensions nonchemically.

Energy Flow

Nearly all Eastern belief systems include the idea that energy flows through our bodies. While these energy flow theories may vary in complexity, terminology, or application, they all generally agree that energy grows through the body similar to electrical current. Physical tension or rigidity is viewed as a block in the energy flow which hinders us from maximizing our potential power.

One such energy flow theory which is applicable to counseling is derived from the science of Kundalini yoga. The theory says we have seven centers or chakras of energy in our bodies. These chakras are located along the spine and correspond to the location of nerve plexis and glands. In Figure 1, a schematic drawing of the body illustrates the general location of the chakras and their corresponding meaning. Blockage in any of the seven chakras prevents energy flow through that block (hang-ups). These blockages can often be seen physically as tension or rigidity. For example, those of us who have blockage in the fifth chakra will have trouble expressing what we want to communicate. Tension or constriction may be seen or felt in the throat or tongue.

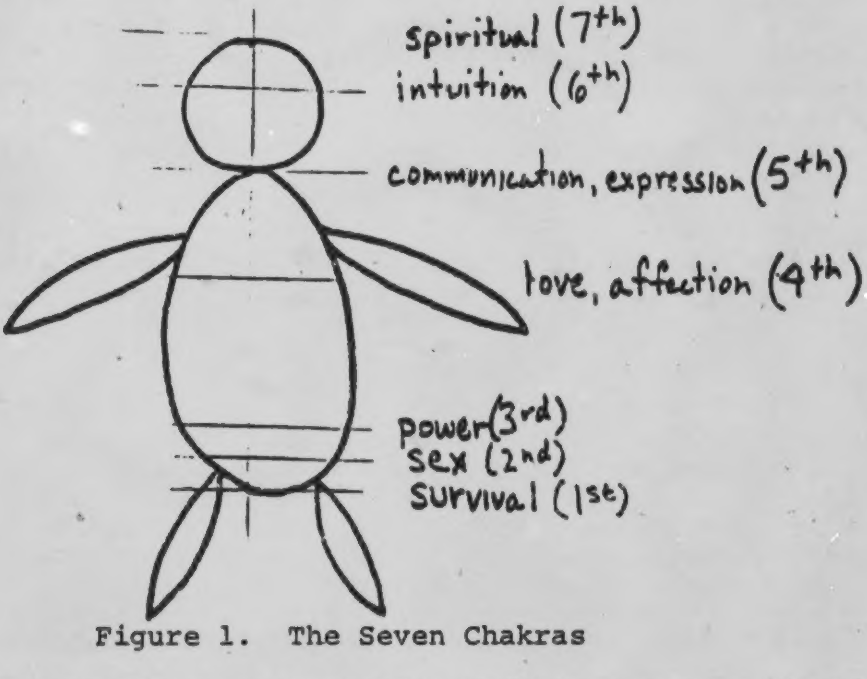

Figure 1. The Seven Chakras

By focusing awareness on each chakra, blockages can be identified and released. Such awareness can be developed by using somatic techniques as well as meditation, encounter, or other therapy.

SOMATIC AWARENESS AND SUBSTANCE USE

In working with substance users, somatic awareness can be utilized in three basic ways:

As a Prevention Alternative to Substance Use

Dr. Allen Cohen has theorized that everyone has a desire for specific levels of experience which can range from relief of physical pain to communion with God. Each of us has many choices to fulfill the specific desire for experience which we have. Substance use is many times an easy and instant way to satisfy such desires. Somatic techniques are ways of satisfying some of the needs we have in a nonchemical way. Somatic techniques are alternative methods for satisfying our desires and can act as a prevention tool in reducing substance use. For example, Kundalini yoga can fulfill my desire for a higher level of consciousness. If I have a desire to control and reduce my tension level, deep relaxation is a method I could use instead of doing heroin.

As a Diagnostic Tool

As a counselor I can use my knowledge of body language to identify problem areas of my clients and to validate my intuitive assessment of my client and her history. If a client avoids looking at me, has much tension in her jaw and throat, sits with her arms and legs crossed leaning back, or has shoulders hunched over her chest, I am getting valuable information as to her self-concept, interpersonal skills, way of expressing anger, degree of defensiveness, and openness to receiving affection. The nonverbal communication expressed in one minute is often more honest and valuable than the information gathered through long hours of verbal psychosocial histories.

As a Rehabilitative or Growth Method

Somatic awareness can be used to enable us to return ourselves to previous states of well-being, to endure stress, or to develop new skills or behavior. Four areas I would like to briefly focus on are: (a) Bodily damage incurred while using substances, (b) Detoxification, (c) Development of insight, and (d) Aquiring new behavior.

(a) Those of us who have a history of substance use have frequently physically damaged ourselves. We have reduced the ability of our bodies to function either by accidents occurring while in a substance induced state, by the act of injecting chemicals into our bodies or by the gradual deterioration of our bodies caused by toxic substances or malnutrition. We can use various somatic techniques to improve the physical condition of our bodies by regenerating damaged tissue or reducing physical limitations. For example, I can stimulate a deteriorated liver by using the energy flow concepts of accupressure or shiatsu. If I was blinded in one eye in an auto accident while drunk, I can use yoga to reduce the rigidity in my neck. Thus, my head can rotate easier, compensating for a lack of peripheral vision.

(b) During detoxification from substances, we can utilize meditation, deep relaxation or yoga to aid us in reducing the tension or stress we experience as we withdraw from substance dependency.

(c) Before we engage in a new behavior, we must be aware of ourselves. As a counselor, we can many times facilitate our clients' development of insight by focusing on their blockages or body presence. Using breathing, deep relaxation, energy flow, and/or centering techniques we can aid our clients in identifying in a very concrete and undeniable way the tension and behavior blockages of their bodies. "One picture is worth a thousand words."

(d) After our clients develop insight, various somatic methods can be used to help a client in acquiring a new desired behavior. If our clients have trouble making contact in interpersonal relationships, we can have them practice talking with us with open postures and with eye contact. If our clients have become aware that they block expression of their feelings by constricting their throats and biting their tongues, they can use yogic chants or relaxation techniques to consciously relax their throat and tongue, thereby opening up their expressing. New behavior requires both insight and practice.

I have explained somatic awareness and counseling as I understand their relationship. My purpose was to stimulate your interest in learning more about somatic growth processes. If your interest in the body has been aroused, I would urge you not to become a "body specialist" but to integrate your new knowledge or skills with your other skills and become a "whole person and counselor."

MODULE 5 : SOCIOLOGICAL IMPRINTS

MODULE 5: SOCIOLOGICAL IMPRINTS

Focus, Objectives & Resources

FOCUS

The most valuable resource a counselor brings to the counseling situation is him/herself. This is well accepted throughout the various modes and types of therapy. Implicit within this tenet is also its corollary. The counselor can also be the most damaging aspect of the therapeutic environment. One of the possibilites for retarding the growth of clients is a counselor's imposition of values and attitudes onto the client. All persons carry with them basic values and attitudes which have sprung from their experiences, both positive and negative. It is essential that the counselor be aware of his or her own "imprinted" values and attitudes and that the counselor be aware that clients also have these imprinted values which guide their own attitudes and behavior. Counseling must be done with an awareness of these imprints.

This module is an exploration of attitudes and values, especially those which are imprinted, in an attempt to gain a greater understanding of self and others. Inasmuch as the deeply imprinted values are those of which we are often unaware and are often the most compelling, this module tends to be more intese than proceeding ones and helps to set the stage for some of the more intensive growth activities which will occur throughout the unit.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- Explain the importance to counseling of understanding the imprints he/she has as a counselor.
- Explain the importance to counseling of being aware of the imprints of clients.
- Explain two ways of using imprints positively in the counseling situation.
- Identify three imprints which he/she possesses and of which he/she was heretofore unaware.
- Identify three imprints which persons different from him/herself possess and of which he/she was heretofore unaware.

RESOURCES REQUIRED

The activites in this module will require:

- A large room with flexible seating
- A trainer
- A facilitator for each eight participants
- A small room for each facilitator
- A flip chart and felt tip pens
- Paper and pencil for each participant

MODULE 5: SOCIOLOGICAL IMPRINTS

Learning Activity Schedule

Activity 1
1 Hour

Trainer Presentation

The trainer will make a presentation on the nature of imprints and how they vary according to gender, racial-ethnic background, age-set differentials, socio-economic status and other life style variations. The presentation will explore the potential influences on the counseling relationship resulting from the values and perceptions arising from these experience bases.

RESOURCES
REQUIRED

- A large room with flexible seating
- A trainer
- A flip chart and felt tip pens
- A copy of the resource paper for each participant

Activity 2
3 Hours

Sub-group Imprint Exploration

The training community is divided into three or four groups by age so that no fewer than five persons are in the smallest group. Sub-groups may be formed by (1) those born before 1930 (2) after 1930, but before 1939 (3) after 1938, but before 1938 and (4) after 1947. Each sub-group is asked to discuss and note on newsprint the main sociological/cultural events which occurred in their lives, emphasizing the formative first 18 years. After listing these events, they are to also list the messages or "imprints" they received which influence the way they see persons, issues and situations now. For example, The Great Depression (event) --- "Don't waste anything"(message) --- have difficulty relating to young persons who have many material benefits, don't save their money, etc.

Each sub-group is to appoint a spokes person who will present (1) the major sociological events of the age-group and (2) the group "profile," how the group tends to view persons (black, poor, older, etc.), issues (crime, welfare, marriage, etc.), and situations (draft evader amnesty, presidential election, busing, etc.).

During the group presentations, each sub-group members sits together in front of the training community for its own presentation.

RESOURCES
REQUIRED

- o A large room with flexible seating
- o A trainer
- o A facilitator for each age sub-group
- o Newsprint and felt markers for each sub-group
- o A meeting room for each sub-group

Activity 3
1½ Hours

Participants go into their static groups, where they are asked to very quietly, and thoughtfully go back into the experiences of their first 18 years. Under four headings (1) Family (2) School (3) Community and (4) Religious Experience, jot down the messages they received to which they are acting or reacting now. After about 20 minutes, group members are asked to share their messages, focusing on the implications for the present.

RESOURCES
REQUIRED

- o Static group facilitators
- o Static group rooms

MODULE 5: SOCIOLOGICAL IMPRINTS

Trainer Guidelines

Activity 1
1 Hour

A short presentation of the nature of imprints and their role in counseling should be made, with special reference to the sociological base of the formation of self-concept, attitudes, values and behavior. Contrast should be drawn between the historic psychological bias of the counseling field and the present movement toward the understanding of the social roles which do so much in the process of development of the self-concept. The imprinting process should be focused on, especially noting the roles imprints plays in positive and negative self-concept development, attitude and value formation, and finally behavior.

The counseling setting is where imprints can be used either positively or negatively. The importance of awareness of both counselor imprints and client imprints is essential to implement a realistic and attainable program of behavior change for the client.

RESOURCES REQUIRED

o A trainer

o A large room with flexible seating

Activity 2
3 Hours

This activity entails dividing the community into constant sub-groups according to attributes of the participants. Subgroups should be made according to obvious criteria so that participants may self select wherever possible. The following is a description of a typical imprint activity procedure. How the activity is ultimately carried out will reflect the specific make-up of the group.

The group is divided into age-set differentials. This is done according to groupings as they exist and should reflect the actual number of age groupings which are evident. Thus there may be two sub-groups,those reared before World War II and those reared after it. Or there may be a pre-war groups, a 1950's group and a 1960's-1970's group. The divisions should be made so that there are no more than ten and no fewer than five persons in each sub-group. The sub-groups are assigned to construct lists according to specific criteria which reflect the responses which are common to that group. Some of the criteria which may be used are:

- Historical events which helped to shape consciousness.
- The roles of people as they grew up, e.g. the way old treated young or vice-versa. This identification of roles will vary according to the division criteria when in gender groups, for example, the focus of roles will be on male-female differentials.

Upon completion of these lists, the groups should, in turn, report and discuss their findings to the community. Time should be left for discussion of aspects of interest to the total community. Often, however, individuals will have specific interests beyond those of the group. Arrangements should be made for them to pursue these interests beyond the confines of the total group process.

RESOURCES REQUIRED

- A lead trainer
- A facilitator for each age-group
- Newsprint and felt markers for each age-group

Activity 3
1½ Hours

The community is then divided according to static groups to focus on personal early years messages received from family, school, community and religion. This division reflects an escalation of involvement. The sensitivity of the static group trainer is important in providing the proper amount of escalation and intensity to maximize the learning. The static group should get highly involved, and participants will not experience the intensity of other's feelings and imprints until they are expressed intensely. The process should continue until the trainer determines that the maximum learning has been obtained.

Static group should then be re-focused to bring full closure to the entire imprint experience, especially working through the implications for counseling.

RESOURCES REQUIRED

- A trainer
- A large room with flexible seating
- A facilitator for each eight participants
- Pencil and paper for each participant

SOCIOLOGICAL IMPRINTS

by

Ross Salisbury

Prepared

by

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SOCIOLOGICAL IMPRINTS

What I want to talk about in this article is what kind of person you come to be as a result of your life's sociological experience. I want also to share with you something about the manner (the process) in which we all become what our social/cultural experience determines for us. Finally, I should like to touch on some of the implications this process has for the client-counselor relationship in which the goal is client behavioral changes.

Let's back up a bit and take a look at what it means to be a human being, at least in part. All humans have certain basic needs to fill--for food, nourishment, for sex, for freedom and independence, for belonging to other humans, for loving, for being loved and for being of some value or worth to self and others. These are internal or intrapersonal (within the self) needs and in our history Sigmund Freud probably gave these needs (drives to fill them) very widespread attention. He focused the world on viewing the human personality in terms his inner, personal needs, especially his sexual drives. He underscored the individual personality and lifted it to a place of supreme importance.

Most of us devote great energies to meet these internal needs. When they are grossly unfilled, we are in trouble as persons. One difficulty in meeting these needs is that they frequently are in conflict with each other. I find, for example, that I have to give up some of my needs for freedom to be myself in order to fill my sexual needs or that I must set aside needs to be loved in order that I may love.

There is another category of human needs, however, which also shapes the personality. We may call these external needs or drives in that they are created by sociological influences (the environment, society, and culture) which impact upon one's life experiences. Some of these sociological influences may be identified as family, church and/or religion, community, and school and/or education. Another such influence may be identified as the major sociological events which impact life. Here we might think of the great depression, World War II, the technological explosion of the forties and fifties, the civil rights movement, Viet Nam, etc.

The great proponent of social consequences has been Karl Marx who subjugated the needs of the individual to the needs of society, or class, and his philosophy stands in stark contrast to Freud who exposed the individual. The point to make here is that to deal with the totality of personality, both intrapersonal needs and needs shaped sociologically must be taken into account. Historically, psychiatry and therapeutic counseling have stressed the Freudian approach, perhaps overly so, to the exclusion of sociologically induced personality traits. For this reason, the remainder of this paper will deal with socially/culturally induced personality traits, which become evident as we uncover a person's standards, norms, values, biases, and prejudices. These traits, determined in a very real way by society, especially in one's formative years, provide the answers to: (1) How I see (feel about) myself. (2) How I see (feel about) others, especially those different from me. (3) Who am I? What we are saying is I am determined by society; I am the product of my sociological life experiences.

In the Substance Abuse Counselors Training we will use the term "sociological imprints." The word "imprint," as we are using it, comes from the discipline of behavioral science. A behavioral researcher, Konrad Lorenz, used the term in describing the initial stimulus given to very young animals. He noted that such a stimulus could arouse a particular response reaction and that it frequently was the case that this stimulus would become the only stimulus which could arouse that response in the animal from then on. As an example, he removed the mother from the sight of a newborn gosling and substituted his hat as the first object the gosling saw. He noted that the gosling would follow the hat wherever it went in the same way goslings would follow their mothers normally.

In a parallel way, psychological theory holds that what society lays on us in our early, developmental years has a profound effect on our responses for the rest of life. The social effect may be very obvious or quite subtle. As a human being, I may be most aware of how society has shaped my life responses or these social effects may be buried within and hidden from me. That is, sometimes society's impact on my personality is overt and obvious. At other times, it is subtle and subconscious. The messages I received about my toilet training, for example, have a subtle effect on how I respond now to genitals, sex, women, etc.

I do not always have to respond in accordance with society's impact on me. I may go in the opposite direction--react in an opposite way. My family, community, and church may have extolled religion, yet my early religious experience may have been so traumatic that since growing up I have never gone to church and have a very difficult time tolerating church people.

Another characteristic of socially induced responses has to do with what I will call "mixed messages." Mixed messages produce confused life responses. Take, for instance, the growing child who will establish some standards for himself with respect to his behavior around his use of alcohol. Depending on where he looks (T.V., parents, church, country club, neighbors, peers, local bar), he will find almost any drinking behavior accepted by some. The fact is that American society does not have a norm for alcohol use. It has many norms and these are in contradiction. The messages he receives about drinking behavior are "mixed."

There is still another kind of life experience which is not uncommon for those of us who find themselves in the substance abuse helping industry. A number of us have had what I will call a "conversion experience" around our substance abuse behavior. Like any deeply moving religious awakening, moving out of addiction (drugs/alcohol) may be a very profound personal experience which stamps one's personality with deep imprints. Although seldom occurring in the formative years (usually much later), the prints are etched deeply in the personality. Here we may have the "ex-addict syndrome" of which we spoke in the Basic Course [Unit A], which markedly affects our relationship with ourselves and others.

Perhaps you will recall some of the messages you received in your developmental years. Here are a few examples:

"Don't speak (children) unless you are spoken to."

"Cleanliness is next to Godliness."

"God

---knows even if I (parent) don't (know what you've done)."

---is loving."

---will judge."

---will forgive."

"Hard work is a virtue."

"Clean up your plate."

"Boys don't cry."

"People on welfare are lazy."

"Catholics are ---"

"Women are ---"

"Black is beautiful."

"--- is scary."

"Nice girls don't ---"

"Pre-marital sex is ---"

"Honor thy father and thy mother."

"Love your neighbor as yourself."

"Poor people are ---"

"Drinking is ---"

"God, guns, guts -- let's keep 'em all."

"Kids are --- these days."

"Work, save, get ahead."

"You shouldn't get angry."

"Waste not, want not."

When I recall some of these messages that I received as a youngster, I get a kind of nostalgic amusement. Not so funny, however, is the way some of them have a manner of complicating my way of looking at myself, situations, and others today, years later. Let me share with you what I mean from my own life. As a kid, church for me was a great experience. I sang in the men boys choir, played on the choir basketball team, sang a few solos for which I received recognition. God, for me, had a special relation to church people. He loved them, forgave them, and expected them to model this behavior among themselves and to others. Now move from 1935 to the early '60's. Yours truly is the rector of a medium-sized congregation in a medium-sized conservative community. Civil rights and Viet Nam are hot issues nationally. Christians should be out front in leading the assault against United States involvement in Viet Nam and practices which relegate minorities to second, third rate status. Right? The church, of all institutions, should be in the action. Right?

The upshot of this for me was to alienate myself from the folks (congregation) I was sent to nurture and ultimately was responsible in an important part for my leaving the parish ministry altogether.

What I wish to emphasize, however, is that *my early messages* about who and what church people should be was most unrealistic in terms of who they in fact were in a small conservative Ohio city. Furthermore, my lack of awareness of who my parishioners were in terms of *their early* conservative, protestant ethic, moralistic *messages*, made it well nigh impossible for me to know who they were. Obviously, our relationship suffered and my role as a helping person became minimal.

This leads me to want to say a few things about sociological imprints and the counseling relationship. The sociological experiences, the people and events which interracted with our lives in our formative years, shape how we see ourselves, shape the image we present to others, shape how we see the issues of life, and shape how we see other persons--especially if they are different from us. They determine how we view marriage, living together with premarital sex, poor people and welfare, minorities and civil rights, government and capitalistic institutions, older/younger persons, drug/alcohol use, etc. etc. They determine as well how we see ourselves; our attractiveness, intelligence, worthiness--our hopes and aspirations.

As counselors, we have the responsibility for managing the client-counselor relationship. That means two persons--the client and yourself. It's very important for you to know where you are coming from or as we so often say, be in touch with yourself. You need to be aware of how those early imprints are affecting your present responses to your client. Are you reacting to your past? Or are you acting objectively in response to your client? A counselor's real attitude has a way of "getting through" in spite of covering efforts. Further, a counselor's attitude about his client with respect to approval/disapproval, success/failure is frequently self-fulfilling. Your client will tend to give you what you expect of him. So much for the counselor and his awareness of his own imprints.

But the counselor is involved, as we have emphasized in the Basic Counselor's Course, with habilitating his client. Among other skills counselors are responsible for assessing are his client's intrapersonal and interpersonal skills. It is critical, then, that he be aware of how his client's sociological imprints have impacted his (the client's) own self-concept (intrapersonal) and how these same imprints influence his responses to others (interpersonal). The habilitation process, then, becomes training his client in these two skill areas where they are deficient.

In summary, sociological imprints of client and counselor impact the client-counselor relationship and need to be dealt with creatively if client behavioral change is to occur. Further, habilitation calls for training clients in inter- and intrapersonal skills which have not previously developed for the client because of the negative impact of his sociological/cultural life experience in his formative years.

MODULE 6 : PRINCIPLES OF BEHAVIOR CHANGE IN COUNSELING SITUATIONS

MODULE 6: PRINCIPLES OF BEHAVIOR CHANGE IN COUNSELING SITUATIONS

Focus, Objectives & Resources

FOCUS

The principles of behavior change are codified and presented in a sequential fashion. This is done in such a way that particular counseling methodologies and techniques can be examined within the context of the principles of change. No specific counseling techniques are either espoused or rejected.

The work of major therapists and schoolsof theraphy are examined in light of the material, and participants have the opportunity to respond to the work of some of the major workers in the field.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- Name seven principles by which people change their behavior in a counseling situation.
- Describe the difficulties encountered when one of the principles of behavior change is overlooked.
- Critique the work of at least one major counseling technique within the context of the principles of behavior change.

RESOURCES REQUIRED

- A trainer
- A large room
- A video tape recorder, monitor & necessary connective devices.
- Video tapes of major therapists at work*
- A flip chart and felt-tip pens
- A facilitator for each static group
- A small room for each facilitator
- A film viewing worksheet for each participant

o A copy of each resource paper for each participant

"Seven Steps of Behavior Change"
"Fundamental Principles of Therapy"

* The series available from Psychological Films showing Rogers, Perls and Ellis working with "Gloria" is recommended.

MODULE 6: PRINCIPLES OF BEHAVIOR CHANGE IN COUNSELING SITUATIONS

Learning Activity Schedule

Activity 1
1½ Hour

Trainer Presentation

The trainer will make a presentation outlining the seven principles of behavior change in counseling situations. The relevance of the seven principles to producing behavior change is established and discussed. The sequential nature of these principles is explored and their value to problem solving is established.

RESOURCES REQUIRED

- A trainer
- A large room
- A flip chart and felt-tip pens
- A copy of each resource paper for each participant

  "Seven Steps of Behavioral Change"
  "Fundamental Principles of Therapy"

Activity 2
45 Minutes

Review of a Major Theraputic Technique

In this activity, the participants will review a video-taped counseling session which demonstrates a major theraputic technique, such as Gestalt, Rational Emotive Therapy, etc. The participants will identify the use of the principles of behavior change in writing on the Film Viewing Worksheet form (sample included with this module).

RESOURCES REQUIRED

- A large room
- A trainer
- A video-tape machine, monitor and connection accessories
- Video-tape of counseling session
- A copy of the Vilm Viewing Worksheet for each participant.
- Pencils

Activity 3
1 Hour

Static Group Discussion

In the small static group participants will discuss the trainer presentation adding their own insights to what has been presented. Then they will share their identification of the film therapist's use of the seven principles referring to their worksheet notes. Some time should be spent by way of conclusion helping each participant formalize his/her learnings from this experience by identifying, understanding and applying the insights realized to his/her own career and personal situation.

Should this activity conclude the day, time should be spent integrating the day's experience and dealing with any personal agendas of the static group.

RESOURCES REQUIRED

- Static group facilitators
- Static group rooms
- Completed Film Viewing Worksheet for each participant

MODULE 6: PRINCIPLES OF BEHAVIOR CHANGE IN THE COUNSELING SITUATION

Trainer Guidelines

Activity 1
1½ Hours

After reviewing the learning objectives for this module, the trainer will make a presentation based on the resource papers. Anecdoes and incidents from the trainer's personal experience should be included to enhance the presentation and provide illustration. The sequential nature of the principles should be stressed and the built-in feedback loops should be emphasized.

The trainer should note the problem-solving potential of the counseling model being presented, and show how it can be used to overcome logjams in the counseling process.

Do not forget that this is not a counseling technique and that it can be employed as a model by persons from various technical persuasions (Gestalt T.A., Rational Emotive, etc.). Throughout the presentation refer to aspects of various therapies which particularly illustrate some phase of the seven step model.

Activity 2
45 Minutes

The video-tape is introduced by emphasizing that the participants should look through the individual style of the therapist to identify his use of the principles. Ask the participants to identify the principles used by the therapist by making a note on the Film Viewing Worksheet for purposes of later recal and discussion.

Activity 3
1 Hour

The static group discussion shall follow the usual format giving each participant the opportunity to EIAG the experience. Conceptual integration is highly important at this point. The discussion should center on the seven principles of change and the therapist's work with respect to them. This is a diagnostic exercise, with the participants identifying the stages of change as they are implemented, omitted, or overlooked.

MODULE 6

NAME__________________
DATE__________________

SEVEN PRINCIPLES OF BEHAVIOR CHANGE

FILM VIEWING WORKSHEET

1. Establish relationship (explicit, emphatic)		
2. Focus on here-and-now pain		
3. Opening feedback channels		
4. Formulation of problem		
5. Explore options/alternatives		
6. Risk/Integration		
7. Action Plan (explore contingencies)		

SEVEN STEPS OF BEHAVIOR CHANGE

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SEVEN STEPS OF BEHAVIOR CHANGE

The following is an outline of the steps people go through to accomplish behavior change. Each step is preparatory to the next. When a counselor is not experiencing the success anticipated, it is often due to the omission or inadequate development of one of these steps. A full understanding of this process will provide each counselor with a built-in self-assessment procedure.

This outline or framework within which to conduct counseling is not a technique or mode of therapy (such as gestalt, transactional analysis, etc.). Rather, it is an overall framework within which any mode of therapy can be conducted.

1. *Establishment of a relationship which is explicit and empathic.* The relationship must be explicit; that is, it must be clearly understood why the client and counselor are together and what is expected. The relationship must also be empathic. The client must feel and understand that the counselor is genuinely interested in the client. This interest needs to be the primary consideration in the relationship.

2. *Focusing on the pain or discomfort in the here and now.* Focusing on the here and now is the only way to solve currently existing problems. Rehearsing history can be cathartic, but rarely therapeutic. There are few lives which have not had sufficient conflict and unpleasantness to allow a patient to dwell on negative aspects of his or her past. If this is what the counselor expects or allows, this is what will occur.

3. *Opening feedback channels in both directions.* Counselors have the responsibility to promote open feedback. To do this they must model both giving and receiving feedback. This implies both honesty and openness in the counseling relationship.

4. *Formulation of the problem.* This often is called "insight" and, as such, terminates many therapies. Often, once the counselor helps the client discover "what the real problem is," the counselor feels his or her job is over. Actually, a clear and accurate formulation of the problem is the step which leads to the steps of behavior change.

5. *Exploring options.* Once the problem is identified, it is important to explore optional behaviors open to the client. After alternatives are explored the counselor should assist

the client in selecting one which appears most appropriate.

6. *Integration.* This step prepares the client to risk the new behavior. In order to do this the client must be able to envision, believe in, and be able to implement the new behavior.

7. *Exploring Contingencies.* It is important to explore the possible success or failure of the behavior, possible reactions to it, what to do if the client fails, etc. This helps the client realize and be prepared for the possible outcomes. In this manner the counselor helps prepare the client for the myriad of reactions which the new behavior may cause. This sets up feedback and further counseling work when the client reports back.

FUNDAMENTAL PRINCIPLES
OF
THERAPY

by

H. Stephen Glenn

Joel W. Warner

Originally
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FUNDAMENTAL PRINCIPLES OF THERAPY

The following seven principles appear to be fundamental in therapy, regardless of one's theoretical orientation or technical approach.

1. Therapy cannot be done outside of a positive human relationship. This relationship is generated by an *active interaction* between patient and therapist without the therapist losing objectivity nor utilizing the client to satisfy the therapist's own needs (*genuineness* -- Rogers).

In order to establish this relationship a therapeutic approach or attitude is necessary which includes the following six facets:

a. *HOPE:* Both the therapist and the client must firmly believe that a positive result will occur as a result of their interaction.

b. *CONFIDENCE:* The therapist must be confident in his own ability and the approach being used. The client's self-esteem is similarly a critical issue and almost without exception is a focus of therapy.

c. *INTRUSIVENESS:* The therapist must work to become a significant force in the client's current life situation. He must intrude between the client and his symptoms, and/or between the client and his current life situation in order to become a significant force for change. The goal here is for the client and the therapist to view themselves as a partnership to deal with the life problems of the client.

d. *EXPLICIT EMPATHY:* To be distinguished from sympathy, empathy is crucial if a therapeutic partnership or alliance is to become established. It is, in fact, the royal road to a therapeutic relationship and allows for more thorough understanding. The empathy must be explicitly conveyed if its full value is to be realized. Empathy involves subjectively placing oneself in the life situation *as if he were the client* in order to understand intellectually and emotionally the patient's existential experience. At the same time, empathy implies the retention of sufficient therapeutic distance so that the therapist's creative coping capacities and strength remain available to assist the client.

e. *WARMTH:* A genuine warmth and concern *must be transmitted to the extent and in a manner that the client* can tolerate without client or therapist becoming overanxious.

f. *LEADERSHIP:* The therapist must accept a leadership role in relationship to the ego strength (ability to cope) of the client and/or his family. The golden rule is *DO for a member that which he cannot do for himself -- and NO MORE!!*

This relationship should not be the end goal of therapy but rather the medium in which therapeutic change is fostered. Thus:

1) If a therapist senses a consistent negative feeling toward him from the client or vice versa, he must stop and examine this feeling *with the client.* Therapeutic progress is impossible, at least towards the mutually agreed upon therapeutic goals, in a persisting negative atmosphere.

2) Similarly, if a client becomes so enamored of the therapist that the therapy becomes diverted from its goals to a struggle in and outside therapeutic sessions to elicit reciprocal feelings from the therapist -- this too, if persistent, requires gentle but firm and direct discussion.

3) *Dealing with the substantive content* of a person's life *will not lead to productive change* unless a positive relationship is present or reestablished. Content discussed in the distant testing atmosphere of early therapy or while negative feelings are rampant will require review in a positive atmosphere for productive therapeutic work and change to be accomplished.

4) Once a strong relationship is established, the *therapist's approval* becomes a *positive* social *reward* and *disapproval* becomes *punishment.* Used in this way the relationship serves the additional critical purpose of *therapeutic leverage* to accomplish change in the direction of desired goals. Behavior therapists utilize this intra-therapy conditioning (reward-punishment) in *planned creative ways* to alter behavior.

NOTE:

The therapist who is emotionless, always in control, nonrevealing of his own particular personality, and relatively silent, fosters fantasies; encourages magical expectations of cure; sets an inappropriate unnatural example of human interpersonal interaction; stirs anxiety; fosters regression; dissolves defensive operations; conveys the message that the patient must largely work on his own. All these are useful with well-put-together patients, with no acute distress, functioning productively, who seek therapy due to chronic existential discontent, i.e., with candidates suitable for psychoanalysis or psychoanalytic therapy.

This relatively reserved, passive, nonrevealing approach is specifically *contraindicated* in other therapies especially crisis intervention and psychotherapy with borderline and acutely irresponsible clients.

2. *PRESENT CENTERED:* What needs are not being met *now* (in the present)? Search continually for real feelings of discomfort (pain) rather than imposing therapist perceptions on the client or passively going along with a client's implicit or explicit discomfort without truly concurring with them. A naivete which assumes little or nothing regarding the client's discomfort is called for, e.g., a client presenting with eleven years of chronic pain and invalidism is frequently ambivalent about achieving a pain-free existence despite his protestations to the contrary. In such a case the real discomfort may be fear of having no pain.

   The wise therapist will benevolently, yet skeptically pursue in detail the nature of the discomfort exhibited by the client. *Many therapists are too timid in exploring feelings.* Human beings are surprisingly rugged. Press and even confront when necessary until there is consonnance between what is expressed and what is felt. *Remember, tears are the client's responsibility.*

3. *FEEDBACK:* The therapist at the *onset* and *throughout* therapy should make sure that the client understands any techniques used, the participation expected of a "good client," and the expected outcome of the therapy.

   Frequent review of what you (the therapist) have been hearing and *feeling*, and how that fits into the client's life when given as explicit feedback produces several benefits.

   a. The client sees you as involved, listening, formulating, empathizing, and working just as you expect him to be.

   b. You ensure that the therapeutic partnership is working on the same set of data since...

   c. The client can correct and add new data in the midst of, and following each feedback exchange.

4. *FORMULATION* (Insight): A statement about why things are the way they are *now*. This is necessary since it allows both the therapist and the client to have a structure on which to place the "Facts" of a member's life. It offers an explanatory model for life events, feelings, and interactions; thus, one can "understand" the present and plan for the future. The specific explanation used seems to be less relevant than the conviction the therapist displays in it. It is also best

when the client develops the insight since the words and concepts used must be within the conceptual grasp of the client, taking into consideration his intellectual capacity and cultural set toward the explanation of emotions and behavior.

5. *ALTERNATIVES:* Generate possible solutions to the problem being experienced. Be creative and don't evaluate solutions before they are generated. Use brainstorming and free association. Often, the client is imposing limits on himself that perpetuate the status quo.

   Once possible alternatives have been generated, eliminate those which the client cannot effect since his behavior change will not produce the desired result if it involves someone else who is not part of the process.

   Next, the client must select an alternative that he can achieve and is willing to risk.

   The therapist must work to foster honest and critical self-observation on the part of the patient while continuously standing off and looking at himself, the therapist. This includes both positive and negative observations. These should be made explicit in the therapy if an attitude or feeling has become persistent within the therapist; especially if the therapy seems to be at an impasse. This will be particularly useful with patients who have difficulty with honest introspection, who might benefit from this type of honest, healthy role modeling.

   Most patients suffer from low self-esteem. Any successful therapy involves maneuvers that hopefully will induce more positive self-concept. Important among these is the necessity of encouraging behaviors that will lead to success with or without the therapist manipulating the environment to insure them.

   Remember, that many people would rather keep their hopeless, helpless self-concept than risk the pain of failing to maintain a positive one.

   Look carefully for the last best period of life performance. Get the best idea possible of the strengths available at that point. Try to get the patient to recapture and work from these strengths rather than spending much time on exploration of the various weaknesses and symptoms of the decompensation syndrome.

6. *IMPLEMENTATION* (risking or behavior change): Explicitly expect behavioral changes in the desired direction outside the therapeutic situation consonant with the therapeutic goals mutually arrived at by both client and therapist.

Insight into continuing chaotic behavior or accommodation to a cruel reality are perversions of therapy's true purpose which is to assist people in their attempts to alter their world intrapersonally and interpersonally with benefit to all they encounter. While insight can help to produce behavioral change in the hoped-for direction -- behavioral change must be fostered by the therapist with or without insight by asking the patient to "fake it" or "pretend" the new behavior despite his or her lack of inner conviction. Example: a housewife acts *as if* she is competent and lovable enough to demand the respect of husband and children, risking rejection and even their loss. This "artificial" behavioral change can result in permanent behavioral changes, that is, new learning if the new behavior is positively rewarded by the therapist and the environment (family). Insight, in fact, frequently comes subsequent to behavioral change.

People distressed by symptoms will present seeking relief. They will tolerate a wide variety of therapeutic measures from psychoanalysis to drugs and electroshock despite the attendant cost in time, effort, inconvenience, money, and side effects to obtain relief. However, despite conscious awareness of an often grossly dissatisfying life situation, they will resist making behavioral changes in relation to significant people in their lives (spouse, children, lover, employer, friends).

The courageous therapist will *resist resorting to symptomatic therapy alone* and will require that the client "risk" changes to accomplish a more self-respecting, need-satisfying existence.

Elicit emotional release when ever possible through explicit empathy as well as cognitive explanation, that is, interpretation on the basis of the formulation. This increases the probability of behavioral change, that is, new learning (intellectual insight arrived at within an atmosphere of emotional release is gratifying and tension-relieving, which itself induces appreciation and cementing of the therapeutic relationship). It also makes the new behavior more relevant and meaningful to the client.

Managing specific emotions: anger, depression, jealousy, guilt, joy, pride, etc., call for similar management. The therapist should evoke the affect and its associated content assertively, empathically, warmly, nonjudgmentally, using therapist approval to reward the sharing of these feelings.

CAUTIONS WORTH NOTING:

a. *ANXIETY:* The therapist must be sensitive to the client's anxiety and titrate it within optimal limits for therapeutic work. If anxiety is too low there will be no involvement in therapeutic work and behavior will not alter. If anxiety is too high, it will be disruptive and no learning will take place.

Anxiety is evidence that the ego is under stress and, if excessive, the patient will fight, flee, or fall apart. Unlike anxiety, depression, guilt, jealousy, etc., are coping techniques as well as emotions and need to be fully explored, as does any symptom, despite the discomfort associated with doing so.

b. Beyond a certain point, *release of emotion* (catharsis) no longer is relieving and productive but rather *becomes a mechanism to avoid engaging in productive problem solving* with the therapist by "wallowing" in emotion. Kind, firm confrontation **is** called for in this situation.

c. *RESISTANCE:* Resistance to experiencing new behaviors that involves sharing an emotion, e.g., grief, or anger, is characteristic of many emotional problems. In general, the therapist should first deal with this resistance. Usually, this involves exploration of the fears (less than conscious, "catastrophic expectation") involved in experiencing affect, e.g., losing control, going crazy, killing, dying, losing loved ones, and so forth.

Resistance to change consistently obstructs the therapist's best efforts. The discomfort of examining long-term solutions to old developmental problems, force of habit, and fear of the consequences of new behaviors are some reasons for the difficulty.

Two forces on the side of therapeutic work are (a) *Pain*, currently experienced by the patient for which he seeks relief: thus, he can be influenced to risk new behaviors in the hope of relief, and (b) the *Positive Relationship* used as a lever by the therapist. In general, patients will take the minimal risks necessary in and out of therapy to satisfy the therapist yet expect symptom relief nonetheless. Patients will soon adjust to a particular therapeutic style or technique when progress has halted. Despite one's best efforts at exploration of the resistance, the fears and so forth often produce enough of an intratherapy minicrisis to remove the therapy logjam. Bringing in spouse for some cojoint sessions, or asking a colleague to consult, becoming more active or much less active in the therapy, or changing your conditions (contract) for participating are some examples.

7. *CONTINGENCIES:* Help the client consider potential consequences of success and factors that might produce *failure*. This helps reduce the potential for rationalization and surprise while allowing the client to begin contingency

planning.

It is very important for the client to realistically consider ways to fail. Self-concept and self-esteem are both negatively affected by continued unexpected failure. Their impact is greatly reduced when they are seen as reasonable obstacles to be allowed for.

The need to plan for success and to explore success in subsequent sessions reflects the need to support the new skills and emotions developing in the client with adequate concept formation (attributions of meaning). Planning for the contingencies of success often helps clients sustain momentum and control beyond the original problem area.

New client behavior also produces reactions in others that must be interpreted and managed by the client in the absence of the supportive therapist. The therapist can greatly extend his support and positive influence by insisting that the client explore and prepare for these contingencies.

MODULE 7 : THE SIX SELVES

MODULE 7: THE SIX SELVES

Focus, Objectives & Resources

FOCUS

This module serves as a capstone to the previous modules, and assists the participants in personalizing the material. A look at the six fold nature of self, and breaking down the individual into those aspects, affords a more thorough understanding of the total self. Once again, the six fold nature of the self is related to the counseling situation with the accent being placed on employing these aspects of the self in the therapeutic process.

The participants will also have the opportunity to compare their self-perceptions with the perceptions which the training community has of them. This assists in the development of self awareness and increases one's knowledge of how he/she comes accross to others.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- Name six aspects of the self.
- Identify three areas of consonance or dissonance between his/her self-perception and how others perceive him/her.
- Describe two advantages of being aware of the aspects of a client's self other than those which the client may admit to or publicly present.

RESOURCES REQUIRED

- A large carpeted room with flexible seating
- A trainer
- Large pieces of newsprint or pads of paper, sufficient so that each participant will have access to several sheets.
- Several packages of coloring crayons

MODULE 7: THE SIX SELVES

Learning Activity Schedule

Activity 1
1 Hour

Pictorial Expression of The Six Selves

In the first activity in this module, the participants will pictorially represent six aspects of the self. Each participant will draw a representation of each of the following:

1) The physical self
2) The intellectual self
3) The spiritual self
4) The emotional self
5) The public self
6) The private self

RESOURCES REQUIRED

- A large room with flexible seating, preferably carpeted
- Two or three pieces of newsprint per person
- A large supply of coloring crayons
- A trainer

Activity 2
1½ Hours

Discussion Groups

In a small group setting, each participant has the opportunity to review the pictorial work of his/her own. The participants give and receive feedback to one another, sharing perceptions and comparing them to the pictures.

RESOURCES REQUIRED

- Space for small groups of 8-10 persons
- A facilitator for each small group

MODULE 7: THE SIX SELVES

Trainer Guidelines

Activity 1

Each participant should be encouraged to feel at ease. The trainer should acknowledge his/her own ineptitude in artistic endeavors and state that artistic ability is not a consideration. Participants should be instructed to use the crayons and newsprints, and do six representations of the aspects of themselves. These six renderings are to represent their physical, intellectual, emotional, spiritual, public and private selves.

The representations themselves can be drawings, impressions, abstracts, designs, ink blots or whatever. Participants should feel that however they choose to do this is fine.

Participants should use tables, the floor or wherever they want to do this work. Typically, a group will be joking and informal throughout. This should be encouraged and even abetted by a few remarks on the part of the trainer, as this helps dissipate the anxiety which is centered on artistic technique. The less anxiety which is generated by fear of exposing artistic inadequacies, the more open and fruitful the experience will be.

Activity 2
1½ Hours

In the small groups each individual should have the opportunity to speak in depth about each of his/her six selves. Also, other participants should enter into dialogue with the individual, expressing their perceptions of the person. The facilitator may need to role model the feedback process. Persons who have behaved in ways other than how they describe themselves should be confronted on the difference between their description and their actions as seen by the training community.

At the conclusion of the sharing period, the groups should then EIAG the experience. It is the responsiblity of the facilitator to make certain that all personal business which has surfaced during the experience reaches closure.

MODULE 8 : COUNSELING PRACTICUM

MODULE 8: COUNSELING PRACTICUM

Focus, Objectives, & Resources

FOCUS

During this module, the participants will try new counseling behaviors and observe, implement and critique the methods which have been the subject of the training to this point. The practicum will also provide participants with mutual work experience on personal growth needs surfaced by earlier modules.

During this module, the participants will receive feedback on their personal counseling styles from their peers and from the trainers. This feedback will focus on ability of the individual counselor to integrate the principles of counseling into their work.

LEARNING OBJECTIVES

At the conclusion of this module, the participants will be able to:

- Identify two areas where they can improve the way in which they counsel.
- Cite two strengths they have as counselors.
- Identify at least one area of strength for each member of their practicum group.
- Give constructive feedback to members of their practicum group, including at least one specific suggestion to each person on an improvement they could make in their counseling methods.
- Operationally define the seven steps of behavior change, citing specific counselor strategies which might be used to accomplish each step.
- Demonstrate the ability to apply the principles of behavior change in the individual counseling situation.

RESOURCES REQUIRED

The activities in this module will require:

- Static group facilitators
- Static group rooms
- Pencils and paper for each participant

Learning Activity Schedule

Activity 1
1-1½ Hours

Individual Counseling Practicum

In this activity, carried out in the static groups, one participant assumes the role of counselor and one participant is the client. In this setting, with the other participants acting as process observers, the client and the counselor involve themselves in a counseling situation. During this session, the client will have the opportunity to experience growth by working on data or dissonance which has been generated earlier in the week.

RESOURCES REQUIRED

- Static group facilitators
- Static group rooms
- Pencils and paper for each participant

Activity 2
½-1 Hour

Group Discussion

Following the counseling session in Activity 1, the observers and the client and counselor will discuss the counseling session. During this activity, both the direct participants and the observers will have the opportunity to examine the counseling process as it unfolded, comparing it to the models of behavior change discussed throughout the week. The counselor will have the opportunity to receive feedback on his/her style and the facility with which the client was moved toward growth and behavior change.

RESOURCES REQUIRED

- Static group facilitators
- Static group rooms
- Pencils and paper for each participant

Activities 3-12 10 Hours	Activities one and two will be repeated until each participant has been in the role of both client and counselor.

RESOURCES REQUIRED	o Static group facilitators o Static group rooms o Pencils and paper for each participant

MODULE 8: COUNSELING PRACTICUM

Trainer Guidelines

Activity 1

During this activity, and subsequent correlate activities, each participant should be in a position to experience real personal growth in areas which have emerged as painful or have created dissonance for the individual during other activities of the week. Particularly, the activities of modules 5-7 may have generated data for this activity. The facilitator should be aware of areas of possible work for each member of the static group by observing the events of the week and facilitating static group activities through the week.

Observers should be instructed to take careful notes of such a character that they will be useful in giving helpful feedback at the close of each session. Review the handout called "Feedback" prior to conducting any counseling sessions to ensure that the nature of the task of the observers are clear. Without clear guidelines for good feedback there will be no learning taking place for the counselor in this experience. Inasmuch as this constitutes the major learning objective for the module, extreme care should be taken to communicate effectively on this point.

The session should be terminated by the counselor, who will be made accountable for that termination in the next acitivity. The facilitator should be certain, however, that the counseling session reaches closure for the client prior to going on to the next activity.

Activity 2

During this period of time, the sensitivity of the facilitator will be called into play. It is during this time that all observers have the responsibility to honestly critique what happened during the counseling session. The facilitator should use the "Feedback" handout as a major guideline here, making certain that the feedback is presented in such a way that it can be heard and integrated by the counselor. Many formats are possible for the structuring of the feedback session and it need not be done the same way each time.

A possible structure for the feedback is to have the counselor report his/her perception of the session as was done on the films viewed earlier, and then have to client respond to the report. The observers could then begin to critique. All observers should participate; and observers with no opinions or no significant feedback to give should be confronted on that behavior. As a counselor, each person must have seen something note worthy in the session, either positive or negative. They have an obligation to participate in the activities and honestly critique the counseling process.

Each separate experience and the total experience must reach closure and each participant should EIAG any part of the experience where necessary. Activity 2, and correlated activities, will provide the opportunity to EIAG most of the data. It is the job of the facilitator to make certain that all the business is done by the end of the module.

TRAINER EVALUATION OF PARTICIPANTS IN COUNSELING **PRACTICUM**

Trainee Name									
Did not participate (note reason on reverse side)									
RESPONSE APPROPRIATENESS (EVALUATION OF 7 PRINCIPLES ACTUALLY USED)									
Responses were appropriate during most of the simulation (no more than one (1) inappropriate response)									
Acceptable response pattern									
Responses were often inappropriate two (2) or less appropriate responses									
RELATIONSHIP MOVEMENT (INDICATES WILLINGNESS OF THE COUNSELOR TO MOVE THROUGH THE COUNSELING PROCESS)									
Counselor moved the relationship at a good pace (no indication of hesitency or premature relationship movement)									
Acceptable relationship movement									
Counselor moved the relationship at an inappropriate pace two (2) or more occasions of inappropriate pacing)									

FEEDBACK*

"FEEDBACK" is a way of helping another person consider changing his behavior. It is a communication to a person (or to a group) which gives that person (or group) information about how he affects others (or how the group is affecting one of its members).

As in a guided missile system, 'feedback' helps a person keep his behavior "on target" and thus better achieve his goals.

SOME CRITERIA FOR USEFUL FEEDBACK

1. It is descriptive rather than evaluative. By describing one's own reaction to another's behavior (a specific bit), it leaves the other free to use it or not use it, as he sees fit. BY AVOIDING EVALUATING LANGUAGE, it reduces the need for the individual to react defensively (learning is well nigh impossible when one's defenses are up).
2. It is specific rather than general. To be told that one is "domineering" will probably not be as useful as to be told that "just now when we were deciding the issue, I felt that you did not listen to what others said and that you were expecting me either to accept your point of view or face attack from you." Speak to specific data.
3. It takes into account the needs of both the receiver and the giver of it. For feedback can be destructive when it serves only our own needs as giver and fails to consider the needs of the person on the receiving end.
4. It is directed toward behavior which the receiver can do something about. Frustration is only increased when a person is reminded of some shortcoming over which he has no control. Helpful level.
5. It is solicited, rather than imposed. Feedback is most useful when the receiver himself has formulated the kind of question which those observing can answer and this places a responsibility for openness on both.
6. It is well-timed. In general, feedback is most useful at the earliest opportunity after the given behavior -- depending, of course, on the person's (or group's) readiness to hear it, support available from others etc..
7. It is checked to insure clear communication. One way of doing this is to have the receiver try to rephrase the feedback he has received to see if it corresponds to what the sender has in mind. Also, both giver and receiver need opportunity to check with others in the group the accuracy of the feedback. Is this one man's impression or is it an impression shared by others. As many reactions as possible. Check with others in the group.
8. Speak for yourself for only you know how you feel.

FEEDBACK, then, is a way of giving help; it is a corrective mechanism for the person who wants to learn how well his behavior matches his intentions.

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* Adapted from "Feedback and the Helping Relationship." Cyril Mill and Lawrence Porter, Editors. *1972 Reading Book*, NTL Institute for Applied Behavioral Sciences, Associated with the National Education Association.

MODULE 9 : COGNITIVE AND AFFECTIVE CLOSURE

MODULE 9: COGNITIVE AND AFFECTIVE CLOSURE

Focus, Objectives and Resources

FOCUS

Module 9 undertakes to wrap-up Unit B, prepare the participant for transition to the back-home situation and to open up the content and process of Unit C.

This module includes: (1) a review of the Seven Principles by looking at a second video-tape of a therapist counseling a client (2) a final cognitive and affective closure of the static groups (3) the administration of the post-test instrument and training feedback questions (4) a brief review of the major concepts presented in Unit B and a plenary discussion of the problems of responding to them in their work-situations and lives (5) an overview of Unit C and an explanation of the written homework assignment for that Unit (6) an opportunity for each trainee and staff member to express feelings to any other member of the training community.

LEARNING OBJECTIVES

Upon completion of the learning activities, trainees will be able to:

- o Give evidence of an increase in knowledge of addictions and counseling in terms of seven cognitive training objectives for Unit B (see Training Objectives - Component B)
- o Give evidence of a statistically significant attitudinal change in at least 75 per cent of four designated areas (see Training Objectives - Component B).
- o Demonstrate an acceptable level of skill in three areas as judged by the trainers. (See Training Objectives - Component B).
- o Identify at least two personal imprints and the consequences of these in current situations and relationships.
- o Identify at least two specific ways in which he/she can improve his/her counseling skills through use of the seven principles.
- o Express the several concepts presented in Unit B and begin to envision what difference these concepts will make to his/her behavior in the back-home work situation.

- Express a rudimentary understanding of the content and process of Unit C.

- Express his feelings at the end of Unit B to another member of the training community or state that he or she is unable to express such feelings.

RESOURCES REQUIRED

The learning activities in this module require:

- A large room with flexible seating
- Small meeting rooms for each static group
- A lead trainer and trainer for each static group
- A video-tape machine, monitor and connection accessories
- Video-tape of counseling session
- A Film Viewing Worksheet for each participant
- Pencils
- A copy of this training manual as reference for Units B and C.

MODULE 9: COGNITIVE AND AFFECTIVE CLOSURE

Learning Activity Schedule

Activity 1
45 Minutes

Review of the Seven Principles of Behavioral Change
Show the video-tape of a therapist counseling a client and instruct the participants to view the tape looking to identify the application of the principles, noting on the Film Viewing Worksheet where and when a given principle came into play.

RESOURCES REQUIRED

- o A large room with flexible seating
- o A lead trainer
- o A video-tape machine, monitor and connection accessories
- o Video-tape of counseling session
- o A Film Viewing Worksheet for each participant
- o Pencils

Activity 2
2 Hours
(More, if required)

Static Groups Closure
Go into static groups to process (EIAG) the seven principles and video-tape.

Static group faciliators move the group discussion into a cognitive closure of the entire training experience soliciting and encouraging feedback being given and received by each participant in terms of personal growth and an operational grasp of the seven principles. An opportunity for affective static group closure should conclude this activity.

RESOURCES REQUIRED

- o A static group facilitator
- o A small meeting room for each static group
- o Each participant's completed Film Viewing Worksheet

Activity 3
45 Minutes

Post-Test and Training Unit B Evaluation

Briefly explain the purpose of the post-test to measure the group movement for training evaluation.

It should be noted that Part One of the post-test should be distributed and collected before Part Two is distributed.

Ask the trainees to respond in writing as honestly and specifically as they can to the following questions about their training experience:

(1) What did you find least helpful?
(2) What did you find most helpful?
(3) Give one positive and negative feedback statement to each member of the staff.
(4) Any other comment to the staff about the training?

RESOURCES
REQUIRED

- Trainer
- A copy of the post-test for each participant
- The four training evaluation feedback questions on newsprint
- Pencils

Activity 4
30-45
Minutes

Review of Unit B, Overview of Unit C

Briefly review the main concepts of Unit B, engaging the participants in a discussion of the implications for them at work and noting the differences between the situation in training and back-home situations.

Give a short overview of Unit C, both as to content and process, noting how these will vary with the experience in Unit B. Note how Unit C will focus on client management, the client's total experience (not just counseling) of the helping program facility. Make the written homework assignment for each participant to write out in detail, step by step, "what happens to a client who goes through my program." Stress that the participants imagine themselves to be the client, noting everything that happens to him/her.

RESOURCES
REQUIRED

- A lead trainer or cycle manager
- A flip chart and felt markers
- A reference copy of this manual
- A large room with flexible seating

Activity 5
15 Minutes

Large Group Affective Closure

Gather the participants in a large training room. Ask them to make a circle by putting arms around one another (or in some other manner to bring them into close physical contact). The lead trainer and staff share some personal positive feelings about other individuals and/or the learning experience just completed, inviting the participants to do the same.

RESOURCES REQUIRED

- Lead trainer and staff facilitators
- A large training room

MODULE 9: COGNITIVE AND AFFECTIVE CLOSURE

Trainer Guidelines

Activity 1 45 Minutes	The lead trainer and each facilitator should have thoroughly previewed the tape from the perspective of the seven principles. The participant instruction should emphasize the same.
Activity 2 2 Hours (More, if required)	This is a critical activity for the static group facilitator. The static group dynamics and personal agendas generated in the previous four days must be closed. The individual learnings around counseling principles must be brought into awareness. The faciliatator must hold these two objectives in delicate balance so that neither activity obiterates the other.
Activity 3 45 Minutes	The post-test administrator should make clear that the purpose of the post-test is to help the staff know if the training objectives have been reached and that the test is used to measure group change rather than individual performance. He should also solicit honesty and specificity in the feedback evaluation responses.
Activity 4 30-45 Minutes	Make a brief presentation of the main concepts presented in Unit B giving examples from personal experience of what some implications for programs might be. Invite and engage several participants to do the same. Note the transference of learning problems in moving from a training situation to a back home program situation. Connect the concepts of Unit B backward to Unit A and forward to Unit C. Touch on content process differences to be expected in Unit C. The trainer for this module should have a thorough grasp of the training manual for the entire course and be able to draw on his own program/counseling experience for illustration. He should be able to employ the E-I-A-G process skillfully. For the homework assignment, it is important to help each participant "get into" the total experience of the typical client going through his/her program. The participants are asked to bring to Unit C a flow-chart of what in fact actually happens (planned and or unplanned) to a client.
Activity 5 15 Minutes	The lead trainer or staff member should feel comfortable with structured group experiences designed to elicit affective response. The staff should be prepared to model positive affective responses about their own training experience in the Unit. A positive, warm closing experience will have much to do with the feelings with which participants leave and the attitudes they subsequently bring to Unit C.

NAME ____________________
DATE ____________________

MODULE 9

SEVEN PRINCIPLES OF BEHAVIOR CHANGE
FILM VIEWING WORKSHEET

1. Establish relationship (explicit, emphatic)		
2. Focus on here-and-now pain		
3. Opening feedback channels		
4. Formulation of problem		
5. Explore options/alternatives		
6. Risk/integration		
7. Action plan (explore contingencies)		

ADDITIONAL RESOURCE MATERIAL

ROADBLOCKS TO COMMUNICATION

Prepared

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ROADBLOCKS TO COMMUNICATION

1. *ORDERING, DIRECTING, COMMANDING.* Telling the other person to do something...giving him an order or command.

These messages tell another that his feelings or needs are not important; he must comply with what you feel or need. "I don't care what you want to do, get those forms filled out right now!" They communicate unacceptance of the other person as he is at the moment..."Stop that talking!" They produce fear of your power. The other person hears a threat of getting by someone bigger or stronger than he. "Finish that food or I'll feed it to you!" These messages engender feelings of resentment or anger, frequently causing the other person to express hostility, fight back, resist, or test your will. They can communicate that you don't trust the other person's judgement or competence..."Don't touch that T.V. set!"

2. *WARNING, ADMONISHING, THREATENING.* Telling the other person what consequences will occur if he does something; alluding to the use of your power.

These messages can make a person fearful and submissive..."If you are late for your appointment you'll be sorry." They evoke resentment and hostility the same way that ordering, directing, and commanding do..."If you don't shape up you can't go home this weekend!" They communicate that you have no respect for the other person's needs or wishes..."If you don't quit daydreaming I'm going to kick you off the team!" People sometimes respond to warnings or threats by feeling or saying "I don't care what happens, I still feel this way." These messages also invite the other person to test your firmness, to do something that they have been warned against just to see if the consequences promised actually happen.

3. *MORALIZING, PREACHING, OBLIGING*...Telling another person what he should or ought do.

Such messages bring to bear on the other person the power of external authority, duty or obligation. People frequently respond to such "shoulds," "oughts," and "musts" by resisting and defending their own postures even more strongly. These messages may make a person feel that you do not trust his judgement... that he had better accept what "others" deem right... "You'd better be good." They may cause feelings of guilt in the other person...that he is "bad" ..."You shouldn't act that way." They may make the other person feel that you do not trust his validation of others, values and ideas..."you must respect your elders."

4. *ADVISING, GIVING SUGGESTIONS OR SOLUTIONS*...Telling the other person how to solve his problems.

Such messages are often felt by the other person as evidence that you don't have confidence in his judgement or ability to find his own solution. They may cause him to become dependent on you and stop thinking for himself..."If your neighbor does that again, call the police." Sometimes other people strongly resent the attitude of superiority that advising or suggesting infers, or feel inferior and think "Why didn't I think of that?" or "You always know better than I what to do." Advice can make the other person feel that you haven't understood him at all... "You can kick the smoking habit if you just try harder."

5. *PERSUADING WITH LOGIC, ARGUING, INSTRUCTING, LECTURING*... Trying to influence the other person with facts, counterarguments, logic, information, or your own opinions.

An especially difficult task for those of us in the helping professions is to stop instructing or using logical arguments when there is a problem of unmet needs. At these times "teaching" often makes the other person feel you are making him look inferior, subordinate, inadequate..."The facts are that heavy use of marijuana leads to loss of immediate recall." Logic and facts often make the other person defensive and resentful. People seldom like to be shown that they are wrong. Consequently, they defend their positions to the bitter end. In addition, people tend to view our lectures as harangues and they tune out quickly. People often resort to desperate measures to discount our "facts," such as: "You are too old to know what is going on," or "You're a square." They may even ignore facts and assume an "I don't care" attitude.

6. *JUDGING, CRITICIZING, DISAGREEING, BLAMING*...Making negative judgements or evaluations of another person

These messages, probably more than any of the others make people feel inadequate, inferior, stupid, unworthy, bad. Self-concepts get shaped by our judgements and evaluations. As we judge a person, so will he judge himself. "It's your own fault. If you weren't so lazy you would get a job and be able to pay your bills instead of whining about it." The other person feels: "I'm a no-good bum." Negative criticism evokes counter criticism... "You're not so hot yourself," or "Since when were you perfect?"

Evaluation strongly influences people to keep their feelings to themselves. They quickly learn that it isn't safe to talk about much of anything, to speak only when spoken to, and then noncommittally. People hate to be judged negatively and respond defensively simply to protect their own self-images. Often they become angry and feel hatred toward the evaluator even if the evaluation is correct. Probably the only message more devastating than negative evaluation is frequent negative evaluation.

7. *PRAISING, AGREEING, EVALUATING POSITIVELY, APPROVING*...Offering a positive evaluation or judgement.

Contrary to the common belief that praise is always beneficial to the recipient, it often has a very negative effect. A positive evaluation that does not fit the other person's self-image may evoke hostility..."I'm not a good swimmer!" or "My hair is not pretty this way, I hate my hair!" People infer that if we can judge them positively, we can as easily judge them negatively some other time. Also, the absence of praise in a situation where praise is frequently used may be interpreted as criticism. Praise given to one person may be interpreted by others as a negative evaluation of them - that comparatively, they are not as good. Thus the use of praise tends to promote competition for recognition, to score "brownie points." Praise is often felt to be manipulative, a subtle way of influencing the other person to do what you want him to do. He feels: "You're just saying that so I'll work harder." Praise frequently embarrasses people, especially when given in front of other people. If you praise you may find that other people become so dependent upon it that they cannot function without constant approval from you.

8. *NAME-CALLING, RIDICULING, SHAMING*...Making the other person feel foolish, stereotyping or categorizing him.

Such messages have a devastating effect upon the self-image of another person. They make him feel unworthy, bad, unloved. The most frequent response of people to such messages is to give one back to you: "Boy, what a grouch!" or "Look who's calling me stupid." Such messages when you are attempting to influence another person are not likely to cause him to examine himself realistically. Instead, he may focus on your unfair message and excuse himself..."I am not inconsiderate. You expect too much!"

9. *INTERPRETING, ANALYZING, DIAGNOSING*...Telling a person what his motives are or analyzing why he is doing or saying something; communicating that you have him figured out or have him diagnosed.

Such messages can be threatening to other people. If the analysis is accurate the person may feel embarrassed at being "exposed"..."You are just doing that to get attention." When the analysis is wrong, as it most often is, the other person will become angry at being unjustly accused. We often communicate an attitude of superiority to other people when we analyze and diagnose, an attitude which the other person resents..."You think you know so much." The "I know why" and "I can see through you" messages tend to cut off further communication from the other person and he learns to refrain from sharing his feelings.

10. *REASSURING, SYMPATHIZING, CONSOLING, SUPPORTING* ...Trying to make the other person feel better, talking him out of his feelings, trying to make his feelings go away, denying the strength of his feelings.

These messages are not as helpful as most of us feel they are. To reassure a person when he is feeling disturbed about something may simply convince him that you don't understand him... "You wouldn't say that if you knew how scared I am." We often reassure and console because we are not comfortable with other people's strong feelings. Such messages tell a person that you want him to stop feeling that way..."Don't feel bad; things always turn out for the best." People can easily see through reassurances as an attempt to change them..."You're just saying that to make me feel better." Discounting or sympathizing often stops further communication because the other person senses you want him to stop feeling the way he does.

11. *PROBING, QUESTIONING, INTERROGATING* ...Trying to find reasons, motives, causes; searching for more information to help you solve the problem.

To ask questions may convey your lack of trust, your suspicion or doubt..."Did you wash your hands like I told you to?" People also see through some questions as attempts to "get them out on a limb" only to have it sawed off..."How much beer do you drink a day?" "Two quarts?" "Well, no wonder you are such a mess." People often feel threatened by questions, especially when they don't understand why they are being questioned. Note how often people answer your question with a question of their own..."Why are you asking that?" or "What are you driving at?" Another "safe" response to questions is the ubiquitous "I don't know." If you question a person who is sharing a problem with you he may suspect that you are gathering data to solve his problem for him, rather than letting him find his own solution..."When did you start feeling this way?" "Does it have anything to do with what is happening at home?" People generally do not want us to come up with answers to their problems. They say: "Adults (read: Ministers, Counselors, Coaches, Leaders, Friends) are all alike. If I tell them my problems they end up telling me what to do." When you ask a question of someone who is talking about a problem, each question limits the person's freedom to talk about whatever he wants to...in a sense each question dictates his next message. If you ask "When did you notice this feeling?" you are telling the person to talk only about the onset of the feeling and nothing else. This is why being cross-examined by a lawyer is so terribly uncomfortable. You feel you must tell your story exactly as demanded by his questions. Interrogating another's communication is not a good way to facilitate problem solving on his part.

12. *WITHDRAWING, DISTRACTING, HUMORING*...Trying to get the other person away from the problem; withdrawing from the problem yourself; distracting the person, kidding him out of his feelings, pushing the problem aside.

Such messages can communicate to the other person that you are not interested in him, don't respect his feelings, or are downright rejecting him..."Boy, it's a good thing the President doesn't have problems as serious as yours." People are generally quite serious and intent when they need to talk about something. When you respond with kidding you can make them feel hurt, rejected, belittled. Putting people off or diverting their feelings may for the moment appear successful, but a person's feelings do not always go away. They often crop up later. Problems put off are seldom problems solved. People want to be heard and understood respectfully. If their listeners brush them aside they soon learn to take their important feelings and problems elsewhere.

ALL OF THE PREVIOUS TWELVE TYPES OF RESPONSES IN ONE WAY OR ANOTHER COMMUNICATE NON-ACCEPTANCE.

ROLLO MAY -- EXISTENCE*

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* Adapted from Rollo May, et al. Eds. *Existence: A New Dimension -- Psychiatry and Psychology;* New York: Basic Books, 1958.

ROLLO MAY — EXISTENCE*

Can we be sure that we are seeing the patient as he really is, knowing him in his own reality, or are we seeing merely a projection of our own theories about him? Are the unconscious ideas of the patient more often the conscious theories of the therapist?

Many psychoanalysts, working separately, became dissatisfied with standard techniques — lacked clear understanding of why cures did or did not occur, or what actually was happening in the patient's existence. They had grave doubts about Freudian theory of man, sought to understand individual's neuroses or psychoses, or crisis situation, not as deviations from preconceived theoretical framework, but as deviations in the structure of that particular patient's existence — his OWN disruption.

Existentialism and psychoanalysis arose out of the same cultural situation; both tried to analyze anxiety, despair, alienation of man from himself and his society.

Freud described the neurotic personality of the late 19th century as one suffering from fragmentation — repression of instinctual drives, blocking off of awareness, loss of autonomy, weakness and passivity of the ego plus various neurotic symptoms resulting from this fragmentation.

Kierkegaard analyzed not only anxiety but especially the depression and despair which result from the individual's self-estrangement.

Nietzsche said the disease of contemporary man is that his soul had gone stale, he had a smell of failure — European man's leveling and dimunition were the greatest dangers. He described how blocked instinctual powers turn, within the individual, into resentment, self-hatred, hostility and aggression.

The chief characteristic of the last half of the 19th century was the fragmentation of man's personality, symptomatic of the emotional, psychological, and spiritual disintegration occurring in the culture and in the individual. Accompanied by developing industrialism as both cause and effect, rationality was being reduced to a new kind of technique, not a part of total man. The sciences which pertained to man went off in separate and unrelated-to-each-other directions — nor were they related to a clear and consistent idea of man. As the culture grew more compartmentalized, radical repression within the individual grew.

Freud developed techniques for understanding and perhaps curing this fragmented personality — he did not see until much later that the individual's neurotic illness was only one side of disintegrating forces which affected all of society.

Kierkegaard foresaw the results of this disintegration upon the inner emotional and spiritual life of the individual — anxiety, loneliness, estrangement of one man from another, and finally the condition that would lead to ultimate despair — man's alienation from himself.

Nietzsche said "We live in a period of atoms — of atomic chaos" — he foresaw collectivism and its eventual destruction of everything.

Kierkegaard and Nietzsche did not underestimate the importance of specific psychological analysis, which was Freud's interest, but they were much more concerned with understanding MAN AS THE BEING WHO REPRESSES — who surrenders self-awareness as a protection against reality and then suffers neurotic consequences.

Kierkegaard tried to understand and disclose human existence. He wrote on self-consciousness, inner conflicts, loss of the self, and psychosomatic disturbance. His question was,"How can you become an individual?" The individual was being swallowed up by rationalism, man's economic objectification, soft and vapid religion. He said our objectivity is impossible, undesirable and immoral - we are so involved in each other and the world that we cannot be content to view truth disinterestedly.

Every question is the "question for the single one" — the alive and self-aware individual; if we don't start with him, we shall spawn, with all our technical prowess, a collectivism of robots who will end up not just in emptiness but in self-destructive despair.

Nietzsche's "will to power" implied the self-realization of the individual in the fullest sense — the courageous living out of his potentialities in his own particular existence. Man should cease allowing his existence to be a thoughtless accident. Individuality, worth and dignity are not given us as data by nature, but are given or assigned to us as a task which we ourselves must solve. He strove to unmask self-deception.

Descriptive Phenomenology: careful and accurate description of the subjective experience of an individual with an effort to empathize as closely as possible with his experiences, through collecting reports from recovered patients describing their experiences. However, this proved inadequate and led to

Genetic-structural Phenomenology: an attempt to define the basic disturbance from which one could deduce the whole content of consciousness and the symptoms of the patient. In melancholics it was found that time is not experienced as a propulsive force, the future is blocked, his attention is directed toward the past, the present is experienced as stagnating. In the compulsive neurotic it was found that he was warding off symptoms, fighting ugly, dirty, repulsive things. His world was devoid of friendly forms — all objects were infected with decay — he was fighting against a background of disgust and destruction.

Categorical Phenonenology:

1. *Temporality:* of crucial importance. For the normal individual, time is experienced as a flowing of life — as spontaneous, living energy, as flowing with a certain speed, and it fluctuates throughout human life, much more slowly for the young child than for the adult — seems to increase in speed with growing and aging.

Time flows slowly when one experiences anxiety, boredom, grief or sorrow — more rapidly with joy, happiness.

The activist fills up every minute with as much activity as possible; lackadaisical individual pays no attention to time; the contemplative person is absorbed with his quiet vision of the universe and the silent growing up of his inmost self; the pseudo mystic, striving to transcend common time with drug experiences in which he feels he is living whole years in a few hours; for some, time is boredom — one must kill it; the compulsive neurotic wastes his time by endless procrastination, then suddenly becomes stingy with it; the depressive arrests time and it flows backwards; some schizophrenics feel as if time were fixed at the present moment (delusion of immortality); manics and seniles (unless depressed) experience increased speed of time. For the manic and some other psychopaths nothing is projected into the future — it is empty; for the depressed the future is inaccessible and blocked — very painful; in some paranoids the past is very inconstant and changing. All these people have different subjective experiences of time. Distortions of the feeling of time result in the distortions of the meaning of life — ex. — when future is empty or blocked life loses its meaning.

There is also "world time" — our personal time must be inserted into the social, historical, and cosmic time. Schizoids and some others live more in their own personal time than in world time. The melancholic is aware of both forms of time, but his personal time flows much more slowly than world time.

2. *Spatiality:* one individual strives to conquer space or explore it, another to keep and defend it, another to organize and utilize it, another to measure it. Some make themselves broad and fill up space, others constrict themselves and have narrow life spaces; one can be rooted in a place or uprooted and wandering; some make real or fantasy escapes. Agoraphobia or claustrophobia patients have very disturbed experiences of space.

Oriented Space: dimensions, distances, planes, boundaries. The major feature is that it has a center of reference that is mobile— the body. There is an infinite variety of oriented spaces, apart from those of our daily experiences: many schizophrenics have anomalies of visual perception— some need inordinate degrees of symmetry, some seem to have added a 4th dimension from which they are watched by invisible observers. The *vertical axis* is the basic axis of human existence to which our most vital experiences are related— life is felt as a constant movement upward or downward. *Distance* also has many implications— the neurotic puts distance between himself and his life goal, the world, his fellow man.

Attuned Space: spatial experience determined by one's feeling tone or emotional pitch, a quality of space in accord with one's mood. One's inside space may be one of fullness or emptiness, expanding or constricting. Love may make one feel close to the object of love, even though there is real distance between. Happiness expands the attuned space, sorrow constricts it, despair makes it empty. Schizophrenics lose attuned space progressively or suddenly, organic brain patients suffer deterioration of oriented space, manic depressives and schizophrenics experience more deterioration of attuned space. In experimental psychoses, there are distortions of both form and space.

Clear Space: horizon, perspective, distinctness, experienced distance— missing in many neurotics and schizophrenics.

Free Space: between individuals— it enables the fortuitous or unforeseen to happen, allows an emotionally neutral space.

Dark Space: obscurity or fog of horizon and perspective -- black, thick, gloomy; since the experienced distance disappears, . . . vital space is narrowed and desocialized. It surrounds the individual and even penetrates his body; it is the substratum of delusions of persecution. The normal opposite of delusions of persecution is the feeling of easiness of life, intimately connected with the experiences of distance and life amplitude.

Luminous Space: Subject is blinded by an intensive light— underlies mystical or ecstatic experiences.

Flight distance: at which an animal takes flight from a man.

Critical distance: at which the animal turns from flight to counterattack — much shorter than flight distance.

3. *Casuality:* includes determinism, chance and intentionality. Melancholic —deterministic; man - chance - complete irresponsibility, where everything happens through pure chance.

4. *Materiality* (substance): Consistency (fluid, soft, hard), tension, shock, heaviness, lightness, hot and cold, light, color, (depressed -- black, manic -- rose) etc.: elements of fire, air, water, earth in patient's subjective worlds.

AIM OF PHENOMENOLOGY: To reconstruct the inner world of experience of the subject -- how he experiences time, space, causality, materiality, and how each relates to the others and to the total inner world. Phen. ignores psychic and physical causality, in contrast to psychoanalysis whose orientation is historical and causal.

Existential philosophy: What is man's most immediate experience -- his own existence. Existence is very different for inanimate objects and for human beings -- "Danein" designates the mode of existence peculiar to humans. Man is not a ready-made being -- he will become what he makes of himself and nothing more; he has the freedom to make choices, primarily the freedom to choose between an inauthentic and an authentic mode of existence.

Inauthentic: man who lives under the tyranny of the crowd, the anonymous collectivity.

Authentic: Man who assumes the responsibility of his own existence. In order to pass from inauthentic to authentic existence, a man has to suffer the ordeal of despair and "existential anxiety" -- the anxiety of a man facing the limits of his existence with its fullest implications -- death, nothingness, (Kierkegaard).

Existential philosophy inspired existential analysis.

Existential psychotherapy: Application of certain existentialist concepts to psychotherapy without regard to phenomenology and psychoanalysis -- no standard system or method.

1. Existential neurosis: illness arising not so much from repressed trauma, a weak ego, or life stress, but rather from the individual's inability to see meaning in life, so that he lives an inauthentic life. He must find meaning in life.

2. Encounter (rather than transference): the decisive inner experience resulting from the meeting of two individuals, experienced by one and sometimes both individuals -- not identification. If the personality of one of them is changed, it means NOT that he copies a model, but that the model serves as a catalyst in whose presence he comes to realize his latent and best abilities, and to shape his own self.

3. Kairos: The critical point in a person's illness when he is inwardly ready for a certain kind of intervention.

Existential analysis: Operates within a larger frame of reference than does phenomenology:

1. Existential analysis does not restrict itself to the investigation of states of consciousness but is concerned with the individual's entire structure of existence.

2. In phenomenology the individual's inner world is unified; in existential analysis the individual may live in two or more sometimes conflicting worlds.

3. Phenomenology is interested only in the immediate subjective worlds of experience; existential analysis strives to reconstruct the development and changes of the individual's world or conflicting worlds; implies a biographi investigation.

Modes: Classical psychology assumes continuity and sameness in the subject; existential analysis states that the "self" changes according to the various forms of existential modes:

1. Dual: mode of intimacy (mother-child, lover-beloved, etc.). Space becomes paradoxically infinite and all-near; distance and proximity are transcended by a spatial mode which has the same relation to space that eternity does to time; the moment coincides with eternity, excludes transcient duration. This inner home of love (Heimat), which transcends space and in which the moment and eternity fuse, forms the core of the normal existential experience.

2. Plural: mode of formal relationships, competition, struggle, coexistence of "one and the other."

3. Singular: mode of man's relationships with himself, including his body. Psychoanalysis deals with narcissism, self-punitive and self-destructive behavior -- existential analysis concept is much broader and includes a wide range of intrapsychic relationships. (Ex.: Inner conflict is seen as a variety of singular mode patterned on the model of the plural mode; autism is not only a lack of relations to one's fellow men but also a specific mode of relationship to oneself.)

4. Anonymous: mode of the individual living and acting in an anonymous collectivity -- used as a means of escaping or fighting.

Aims: To investigate the life history of the patient, but not to try to explain this life history according to the teachings of any particular school, or according to categories; to understand this life history as modifications of the total structure of the patient's being in the world; to understand man by cutting below the cleavage between subject and object. Man is not an object to be controlled, analyzed, understood as a "thinking" being, but rather as an existing, experiencing organism. Existence refers to coming into being -- BECOMING. Crucial question: what is abstractly true and what is existentially real.

Therapeutic implications: existential analyst seemingly performs like an ordinary psychiatrist -- studies everything about the patient; reconstructs his biography. However, he observes and classifies within the existential framework, achieving much deeper understanding. Errors in temporality, spatiality, etc., can be reconsidered and readjusted. Reconstruction of the subjective world of the patient is more than an academic exercise; he is not inert material; he reacts to the kind of approach. If he is objectively, intellectually, scientifically studied, he may feel that his inner self is being disregarded.

Try to discover what keeps the patient from accepting freely his potentialities.

Emphasize the present and presence -- the relationship of the therapist and patient is a real one -- therapist must see the patient as someone to be understood rather than an object to be analyzed -- "the patient needs an experience, not an explanation."

Therapist should be aware of whatever in himself blocks full presence; real confrontation between two people can be profoundly anxiety-creating; it is much more comfortable for the therapist to focus on the patient as an object and himself to be a manipulator of the object.

The aim of therapy is to have the patient experience his *experience as real*, fully become aware of his potentialities and become able to act on the basis of them. The neurotic's existence has become dark, clouded over, blurred -- therapy should illuminate his existence. The neurotic is overconcerned about the Umwelt, underconcerned about the Eigenwelt; the therapist must guard against the patient's taking over the Eigenwelt as his own emerges and seems to be weaker than the therapist This is quite different from helping the patient to "adjust" to the culture, which implies a further deadening of his existence.

Commitment: Truth exists only as the individual himself produces it in action. What is going on, that the patient has not found some point in his own existence to which he can commit himself unconditionally; everyone constantly faces the threat of nonbeing if he allows himself to recognize the fact; the therapist is doing the patient a disservice if he takes away from him the realization that it is entirely possible he may forfeit his existence, and that may well be precisely what he is doing at this very moment if he is denying his existence. "I know only two things --(1) that I will be dead some day,(2) that I am not dead now. The only question is what shall I do between those two points."

Refrain from evaluations of any kind; do not look for bizarre, absurd, illogical expressions; rather try to understand the particular world of experience of the patient -- how it is formed, how it falls apart; see it as a gestalt rather than a set of symptoms.

Try to transcend the split of Being into subject (man) and object (thing, environment) and replace it with the unity of existence and "world." (In psychoses, the freedom of letting "world" occur is replaced by the unfreedom of bing overwhelmed by a certain "world-design." There are as many worlds as there are psychotics.)

Being in the world: Common problem today for all -- isolation, alienation, moving about in a haze, no direct-sense-connection with own world -- adds up to lack of communication or interpersonal relations. Also man is alienated from the natural world -- he has been busy gaining power over nature -- now he is estranged from it. Also he is estranged from his own body. Person and his world are a unitary, structural whole -- self and world imply each other. This does not mean a spatial arrangement or his position in his environment -- there are other world modes.

World is the structure of meaningful relationships in which a person exists and in the design of which he participates; it includes past events which condition his existence as he relates to them, is aware of them, carries them with him, forming them in every minute of relating, plus all future possibilities beyond his "culture."

World Modes

Umwelt: all the natural world, objects about us, biological needs, instincts, natural laws and cycles -- all the world that would still exist if we had no self-awareness -- the world to which each must in some way adjust.

Mitwelt: world of interrelationships with human beings -- not adjustment or adaption -- this makes of the other an object. The essence of relationship is that in the encounter both persons are changed unless those involved are severely ill or have no degree of consciousness -- in which case there is no mutual awareness.

Eigenwelt: made of self-awareness, self-relatedness; the basis on which we see the real world in its true perspective and on which we relate to it -- what something in the world means to me. Without this the individual is aridly intellectual, loses vitality and the sense of reality of his experiences.

These three worlds are interrelated and condition each other. Man lives in all three simultaneously. The reality of being in the world is lost if one of these modes is emphasized to the exclusion of the other two.

Transcending the immediate situation: Man has this capacity; existing involves a continual emerging, a transcending of one's past and present in terms of the future. He can bring the distant past and the long-term future into his immediate present. This capacity is an inseparable part of self-awareness -- the basis of freedom of choice.

Anxiety, phobias, guilt: Anxiety must never be separated from "world"; it emerges when world becomes shaky or threatens to vanish; the emptier, more simplified, more constricted the world-design to which an existence is committed, the sooner will anxiety appear and the more severe it will be.

Phobia is always an attempt at safeguarding a restricted, impoverished "world"; anxiety expresses the loss of such a safeguard, the collapse of the world, and thus the delivery of the existence to nothingness.

Anxiety is the experience of the threat of imminent nonbeing, not something we have but something we ARE. It involves inner conflict between being and nonbeing; it occurs at the point where some emerging potentiality or possibility of fulfilling his existence faces the individual. This possibility destroys the present security; the present security then attempts to destroy the new emerging potentiality. Thus anxiety is connected with the problem of freedom -- it is the realization of freedom as a potentiality before this freedom has materialized.

When the individual denies these anxiety-producing potentialities, his condition is GUILT. The individual is GUILTY, NOT HAS GUILT. He is guilty when he denies or refuses to accept any aspect of himself (Eigenwelt), when he fails to perceive totally the other person, thus doing him a disservice (Mitwelt), or separates himself from nature as a whole (Unwelt).

Ontological guilt: Everyone participates in it; no one fully fulfills his own potentialities, sees his fellow men with no distortions. It does not come from cultural prohibitions, introjection or cultural mores -- it is rooted in self-awareness. It is not morbid or neurotic guilt -- this is avoidance of ontological guilt (same for anxiety). Once accepted, it is not morbid or neurotic. Ontological guilt does not lead to symptom formation but has constructive value -- it leads to humility, sharpened sensitivity in relationship to others, increased creativity in the use of one's own potentialities.

Contributions: Main contribution is the understanding of man as BEING. Man can be understood only in the context of the structure of his being or existence. Grasping of the being of the other person occurs on a quite different level from our knowledge of specific things about him. If we consider man as capable of being analyzed and reduced to original data we may end up with an imposing system of substances which we may call mechanisms or patterns but the MAN disappears -- we can no longer find the ONE to whom this or that experience has happened.

We subordinate existence to function -- what a man does. BEING is what remains AFTER we have extracted, analyzed, and understood all of a man's drives, instincts, and mechanisms.

BEING: someone in the process of being something, a source of potentiality by which a man becomes what he truly is. BECOMING is a better word.

HISTORY AND DEVELOPMENT OF PSYCHOTHERAPY

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HISTORY AND DEVELOPMENT OF PSYCHOTHERAPY

Early Babylonians, Egyptians, and Greeks used magic, music and prayer for quieting patients and luring demons from their bodies. From about 1530 on, many doctors became aware of the value of kindness and humane treatment for mentally disturbed patients.

Mesmer (1734 - 1815) started by using magnetized iron, having a patient sit with back to north, used soothing music, made passes in front of patient's face, stared into his eyes; patient would fall into a trance during which he would be told that his symptoms would disappear. French scientists, testing Mesmer's theory, found that a patient could be helped by being deceived into believing he was in the vicinity of one of Mesmer's magnetized objects; also that no results were achieved if he was in the vicinity of it but didn't know it. They concluded that "imagination does everything - the magnetism nothing." Mesmer's method was discredited because of this fallacy and because of the exaggerated claims made by some of his followers. (By 1840 mesmerism was being used effectively for anesthetizing surgery patients and was often used until the discovery of anesthetics.)

Braid, an English physician used induced sleep, called it "hypnosis" and explained it in terms of fatigue of the sensory nerves.

Liebeault (French) founded a clinic, treated patients by hypnotizing them and telling them that their symptoms would disappear. (Modern method of "hypnotic suggestion" descended from this school.)

Charcot, a famous neurologist in the latter half of the 19th century, gave many demonstrations working with hypnotized hysterics, but his main interest was experimentation, not therapy.

Breuer (Vienna) discovered that one of his patients who had paralysis of 3 limbs, disturbances of sight and speech, inability to eat, nervous cough, dual personality, plus many more symptoms, would get temporary relief after talking to Breuer during a hypnoid state (caused by her dual personality.) One day she told him the details of the *first appearance* of one particular symptom, after which the symptom disappeared. He had her do this with her other symptoms, and since her hypnoid states were unreliable (in time and duration) he induced hypnoid states by hypnosis. He called the process *catharsis* - his patient called it the "talking cure."

Freud (1856 - 1939), was impressed by Breuer, but found hypnotism unsatisfactory as not everyone responded. Also patient sometimes could not recall what had happened during hypnosis. Another doctor suggested that Freud lay a hand on patient's forehead and tell him that the memory would return. This worked and also showed Freud how to dispense with hypnosis. He had patient concentrate upon remembering when the symptom first appeared; if patient had difficulty, recall was facilitated by Freud's placing his hand on patient's forehead. He called this technique "psychoanalysis."

The history of psychoanalysis for the next 30 years -- 1896-1926 -- is the intellectual biography of Freud.

Primitive Psychoanalysis: *Aimed* at inducing the patient to recall traumatic incidents from early childhood, through the *techniques* of concentration and free association.

Theories:

1. *Traumatic incidents* were thought to be sexual seductions by an older child or an adult. At first Freud rejected the emphasis on sex expressed by other physicians, but his experiences with repressed Victorian women made him reluctantly come to similar conclusions.

2. *Repressions* - repressed material always carried some emotional distress.

3. *Resistance-* was the force which kept repressed material from appearing in consciousness.

4. *Abreaction* -- revival of a memory had NO therapeutic effect unless accompanied by the strong and distressing emotion that accompanied the original experience.

Later Freud began to suspect that some of the sexual "seductions" were fictional. However, they appeared so frequently and were accompanied by such real emotional distress, that he could not disregard them. He concluded that the memories were of fantasies. He studied the development of his own children and concluded that children did have sexual feelings - that psychoneurosis still had its origin in the sexual life of the child, but it could have been wishful thinking, not actuality. He enlarged his concept of the unconscious, stating that personality was the interaction between 2 psychic forces - pleasure-seeking libido (love) and aggression (hate). He changed his theory of psychoneurosis from being caused by a traumatic incident, to that of faulty development of the individual's unconscious.

His technique changed from inducing the patient to recall a sexual seduction, to releasing from repression the instincts which had been too severely repressed in infancy. He made no suggestions and dropped all techniques except free association, but soon found this very limiting.

He noted the prevalance of *dreams* appearing in free association and developed techniques of interpreting dreams which he said were attempts to fulfill in fantasy some repressed wish. From the dream material he made certain inferences about the content of the unconscious. However, the dream material is masked or distorted, so he started to use symbols and used this same technique with the waking thoughts of the patient. With interpretation, he could induce the patient to recognize, accept and make conscious, his present attitudes and emotions. (He used interpretation only as an adjunct when unable to get satisfactory results from free association.)

Transference: during analysis, released feelings of love, sexual attraction, dislike, etc. for a parent were transferred to the analyst. Freud would analyze the transference by showing the patient its childhood origin. (Because of the phenomenon of transference, Freud limited his contact with patients to his office.)

Later Theories: ambivalence, ego-id-superego structure, defense mechanisms (regression, sublimation, projection, isolation.)

FREUD'S MAJOR THEORIES:

1. There exists in man, in addition to the conscious part of his mind, an unconscious part of which he is unaware but which governs much of his behavior.

2. Man is driven by 2 main instincts: self-preservation (hate) and procreation (love).

3. From birth, man undergoes psychosexual development which matures in adult sexuality.

4. The main psychosexual crisis that everyone has to overcome is the Oedipal conflict - child becomes emotionally attached to the parent of the opposite sex and wishes the parent of the same sex out of the way.

5. All little boys fear castration because of their incestuous wishes. All little girls envy boys for possessing a penis.

6. There are two self-preserving psychic forces: repression which helps man escape those memories and desires he believes to threaten him, and resistance which blocks knowledge of repression and keeps him from admitting the dangerous truths that have been repressed.

7. The mind of man is divided into 3 parts - ego, superego and id.

8. Dreams are essential to his well-being, physically and psychically.

9. Traumatic childhood experiences and fantasies about them can later haunt an adult and cause severe distress.

10. Every child wishes to possess his parents' love completely - when parent shows love for a brother or sister, the child feels deprived of love - hates brother or sister and wishes him or her dead.

11. Civilization is the result of the sublimation of our aggressive and sexual drives into socially-approved channels.

12. Normal personality - conflicts between instinctual drives and morality standards have been comfortably resolved.

THE MIND: consists of the conscious, unconscious and preconscious. The unconscious lacks any sense of what we call reality - it cannot distinguish between a truth and fantasy. Therefore we live in 2 different kinds of reality - the actual one of our environment and our "psychic reality" composed of dreams (waking and sleeping) and fantasies. If these are very strong, we act as though they were true, even though they may be false. The unconscious stores memories of past experiences (real and imaginary) and their accompanying emotions.

The preconscious is an intermediary between the conscious and the unconscious - it holds thoughts that could easily slip into the conscious. It is a repository and a censor - protects from knowledge that might be too dangerous to admit to consciousness directly.

ID, EGO AND SUPEREGO: ID contains primitive impulses and passions - completely lawless - no moral sense - pleasure at any cost - no sense of time or order - full of contradictions - love and hate exist side by side - new-born infant is almost wholly id.

EGO - reason, sanity, control of the id - ego tries to make sense of the environment and of our experiences - tries to live by the reality principle instead of the pleasure principle - self-esteem, self-respect, pride all linked to the ego.

SUPEREGO - conscience - teachings of parents and society - if there is too much tension between ego and superego, we feel guilt.

All three parts direct our lives - the id and superego engage in fighting - the ego is the battleground between passionate id and strict conscience - if ego is strong, person can direct the impulses of the id so that life becomes rich and rewarding, rather than self-punishing. Primitive instincts can be used constructively and imaginatively. If superego is in charge and moral code too strict, guilt and unhappiness results - if id is in control, ego is weak, self-esteem is low - resulting in unhappiness also.

PLEASURE PRINCIPLE - infant starts life narcissistic - what brings him pleasure he loves - what brings him pain he hates - just wants to satisfy his needs. As he begins to grow up, he begins to want his parent's love - sometimes this is withheld if he follows the dictates of his id impulses - conflict ensues - he must learn to put off immediate gratification and try to adjust to the "reality principle."

FANTASY - interwoven with instinctive drives - part of one's imaginative creative spirit - attempt to explain mysteries in life in a way that is least harmful to self-respect.

INFANTILE SEXUALITY AND PSYCHOSEXUAL DEVELOPMENT

Freud's use of the word sexuality encompasses all that is involved in "sensuality."

Libido - energy that is in all feelings of love (people, objects, ideas) - if there are no love objects available to the child, libido may remain attached to himself - as an adult, he is unable to love another person.

Complex personality traits derive from forms of libido:

oral libido - insatiability, desire to exploit

anal libido - orderliness, hoarding, obstinacy, sadism

genital libido - capacity to love

Stages in psychosexual development - oral, anal, and genital. First 2 occur before the age of 5 - genital during adolescence. From 5 to adolescence is the latency period.

Oral - feeding, pleasurable sensations of the mouth, sucking, biting.

Anal - bowel control - Freud felt there is some erotic pleasure associated with excretion - also that this is the period when child first discovers he may have power over his parents.

Genital - sexual maturity.

Too much frustration at any one of the 3 psychosexual stages may lead to sexual conflicts.

DREAMS

In ancient times dreams were considered to be ancestors speaking, omens, angry or pleased gods, signs of good and bad luck, etc. There was writing about dreams as early at 1800 B.C.

Plato quoting Socrates: dreams reveal man's desires "which are awake when the reasoning and human ruling power is asleep; then the wild beast within us, --- goes forth to satisfy his desires ---. In all of us, even in good men, there is a lawless, wild-beast nature, which peers out in sleep."

Aristotle was the first to speak of dreams as part of man - not something outside him

Cicero - dreams have no order and "no one image has the same meaning for different people - it is not constant even for the same person."

Lucretius - dreams a product of the unconscious mind, a fulfillment of wishes, and they revealed guilt.

FREUD synthesized all previous valid ideas on dreams and added his own theories:

1. Dreams mirror wishes and fears, primarily secret wishes.

2. Most dreams reflect sexual wishes and fears.

3. We dream about the hidden instinctual desires which fulfillment we must unconsciously deny, or that which is forbidden.

4. No one image has the same meaning for any 2 people.

5. Dreams mirror intense emotions - thse we believe too frightening to admit to the conscious self - furies, hungers, guilt - and from them get gratification for all past emotional deprivations.

6. Dreams condense - use symbols. However, he felt that symbolism and dream interpretation were only a part of unraveling the material in dreams and could never replace free association as effective therapy - interpretation of symbols was of value only as a complement to free association.

7. During sleep the conscious relaxes - the preconscious takes over and allows some of the forbidden material to be remembered.

8. Dream fantasies are usually based on a fragment of the truth.

Individual Psychology and Counseling - Adler

Adler - (1870-1937) was not analyzed by Freud, but was affiliated with him in study groups and publishing a journal. He broke away when he began to disagree strongly with Freud and formed his own group which he called the "Society for Individual Psychology."

Main divergencies from Freud:

1. Freud was interested in the patient's experiencing repressed emotions - Adler in the patient's recognizing unpalatable facts about himself and seeing how his symptoms fitted in with these facts.

2. Freud was concerned with origins of neuroses - Adler was interested in "healthier" goals - showing patient errors in his present goals and helping him substitute social goals for his present defective ones.

3. Neurotic symptom - Freud saw this as a result of conflict between irreconcilable instincts. Adler saw it as a result of the ascendant instinct - claimed this enabled him to treat the individual as a whole person, which was his goal. Individual psychology meant "psychology of the indivisible personality."

Other Adlerian theories:

ORGAN INFERIORITY: When an individual has a weak organ, he tends to compensate by overdeveloping in another area - he also does this psychically. Everyone has a general sense of inferiority and will tend to find a way to compensate. If he does this through direct competition, it is not neurotic. If he distorts his compensation, (such as withdrawing from competition into illness) he is neurotic and develops a neurotic "life style." (Women suffered from inferiority complex more than men because of male dominance in society.)

COMMUNITY FEELING: Tenderness, friendship, love. (opposing force was domination or need for power stemming from inferiority feelings.)

TECHNIQUE: Chiefly interpretation in terms of patient's aggressive striving for superiority. He did not wait for patient to become aware of his behavior, feelings, thoughts, symptoms, etc. - as soon as Adler saw these clearly, he would tell the patient. He also tried to reeducate the patient and make him a more constructive member of society.

ANALYTICAL PSYCHOLOGY - Jung

Main divergences from Freud:

1. Freud searched for sexual features - insisted that infantile sexual development was at the root of all problems - Jung accepted sexual discussion but did not search for it and when it did arise, he looked for explanation for the libido's taking that particular form.

2. Jung strongly interested in mythology and dissociation. Freud felt that the unconscious consisted entirely of memories, fantasies, desires and emotions repressed during childhood. Jung accepted this but added "collective unconscious" (inherited memories, fears, etc.) and potentialities of character which the patient had been unable to realize.

Other Jungian theories: Child is born with certain constitutional dispositions (introversion, extroversion, sensations, logic,emotions, etc.) AND ways of thinking, feeling, and behaving which he inherits from remote forebears. Neurotic selects an archetype and then fails to fit it. Some features or eccentricities of the personality can be valuable and do not have to be "normalized" or analyzed out of existence. He agreed with Freud that therapy often consists in removing patient's repression and reconciling him to less savory aspects of his personality and added that the therapist can help the patient fully develop all his unconscious potentialities.

Techniques:

1. Re-education - no setting of goals by therapist.

2. Catharsis - when necessary - not in all cases.

3. Interpretation - Jung's main technique - he felt sure that the patient could not possibly arrive at insights referring to material in his "collective unconscious."

4. Dream-interpretation - very important - therapist should point out the dream's myth-like aspects plus its diagnostic or prognostic aspects.

5. Free association - used this less than Freud - he used word-association tests as a quicker means of getting a rough idea of what the patient was repressing - any abnormal response indicated a problem and the diagnosis was formed.

6. Transference - Freud felt that the therapist should remain completely impersonal and detached - Jung believed the therapist could be helpful by reacting naturally toward patient's attitudes - adding that every therapist should have a complete analysis so that his reactions would be "healthy" and thus help the patient understand his transference.

7. Picture-making - induced patient to draw or paint subjects of dreams and fantasies - by doing this, patient takes more responsibility in the act - fantasy becomes clearer.

Otto Rank: Rank objected to Freudian analysis, saying it aimed at changing the neurotic person into an ill-defined, formless, average person. He believed the neurotic had more in common with the creative person - both are strong-willed, except the creative man's will is affirmative, the neurotic man's will is negative. Because of conflicts, the neurotic is unable to live up to his aspirations and therefore he denies them - because of his denial of will, he suffers from guilt feelings. The individual needs faith in himself, his own truth, illusions, and developing his own ethical standards.

Rank recognized the positive, creative directional nature of man's striving. He spoke of "will" and rejected the idea of man being pulled and pushed by impersonal forces. The neurotic is at an impasse; he is bound by conflict of positive will and fear of the consequences of will. To will without guilt, to be oneself without fear, is the mark of health.

Therapy seeks to free the person from this conflict, to assist him to gain acceptance of himself in all his uniqueness and with all his ambivalences. Rank puts the patient directly at the center of the therapeutic process - the therapist is available as "ego-helper", working on those aspects of self felt by the patient to be disturbing; more concerned with present than past; less concerned with content of patient's life and more with his immediate experiences of living in relationship to therapist; avoids giving love as this would create dependency; makes no attempt to educate as this would intensify the neurotic conflict.

"Real psychotherapy is not concerned primarily with adaption to any kind of reality but with the adjustment of the patient to himself - the acceptance of his own individuality or of that part of his personality which he has formerly denied."

Rank's psychotherapy was the fore-runner of client-centered or non-directive therapy.

Birth trauma: Two factors - 1. a desire to return to the womb, expressed in a need for dependency; 2. a desire for rebirth, "will" to grow, to achieve self-actualization. Rankian analysis emphasizes the resolution of the conflict between these two contradictory strivings. The therapist concentrates on mobilizing constructive elements in the personality so that the patient can resolve his fears of separation and achieve growth and independence.

Non-directive or client-centered therapy:

Rogers (1902 -) Originally interested in personality testing, formulating diagnosis, and giving advice based on the results. He gradually shifted his interest to the patient-therapist relationship and psychoanalytic orientation but avoided its terminology.

Theory: Catharsis (Freud), insight (Adler), and natural drive for recovery. He considered insight the most important factor in therapy but stressed intellectual rather than emotional insight.

Technique: Inducing patient to talk as freely as possible about all aspects of his symptoms or difficulties - the therapist is merely a clarifier or mirror. Topics are chosen entirely by patient (not so with Freud or Adler.) Rogers made no effort to induce catharsis of childhood experiences, gave no interpretations, did not use free association.

Levy and Taft: Focus on the present rather than the past. Instead of having the patient retrace his developmental steps and relive emotional experiences, feelings and attitudes are handled in terms of the present therapeutical relationships, in the belief that positive growth can be achieved in this relationship itself. The emotional interaction between patient and therapist permits the free expression of strivings and feelings with complete acceptance and understanding, making an atmosphere in which the patient can realize his potentialities and, through insights gained in this relationship, he is able to re-adapt himself to life situations.

Snygg and Combs (phenomenological): Behavior is determined by the individual's own perceptual field. The therapist's task is to facilitate the patient's exploration of his own perceptions by communicating to the patient an emphatic understanding of the world as he, the patient, sees it. At the same time, the patient is provided with an opportunity to bring about changes in his perception of himself that lead to self-realization and self-enhancement.

Focus is on the individual - not the problem. No diagnosis is made. The therapist has a permissive, non-judging and accepting attitude in order to allow free expression of the patient's own feelings and attitudes. The therapist responds to the individual's emotional experience rather than the intellectual content of his verbalizations. No effort to guide him, provide information, give advice.

Hypothesis of client-centered or non-directive therapy: In each individual there are residual growth potentials which need only to be released to enable him to achieve maturity. Maladjustment is not due to lack of knowledge or failure in problem solving but rather to a blocking of knowledge by feelings and attitudes that are not understood by the patient. The main role of the therapist is to provide a unique situation of acceptance and recognition, to refrain from imposing his own patterns and values on the patient, so that self-understanding and growth may take place directly in the therapeutic relationship.

Techniques: Emphatic reflection of feelings, rephrasing of verbalizations, to help patient clarify facts for himself and recognize his own emotions without fear.

1. Attempt to understand what the client is saying with reference to content, feeling and import to the client, and to communicate this to him.

2. Condense or synthesize the expressed feelings of the client.

3. Accept what client has said, implying that it has been understood.

4. Define, when relevant from the client's point of view, the nature of the therapeutic relationship, expectancies of the situation, and limits of the therapist-client relationship.

5. Convey to the client a sense of acceptance and of confidence in his ability to handle his own problems.

6. Answer questions and give information when relevant to the treatment, but may refrain when it may implement dependency.

7. Actively participate in the session, keeping alert, trying to catch nuances of feelings, interrupting if necessary to make certain of understanding what the client is saying and feeling.

8. NONE of the following: interpreting client's behavior within the therapist's hypotheses or theories; trying to promote insight directly; advising, moralizing, praising, blaming, teaching, planning programs of activities; diagnosing; asking probing questions; suggesting areas for exploration.

Primary difference from other schools: Leaves more of the responsibility for the course and direction of therapy to the client - choice of topic, finding of meanings, moving ahead or resting while in the comfort of old defenses, and final resolutions.

Directions of change in therapy: Movement is from symptom to self, from environment to self, from others to self, and from past to present. Client learns that it is safe to leave his symptoms, others, environment, etc. and focus upon the discovery of "me, here and now."

Other values derived from therapy: Increased differentiation of the perceptual field. The individual abandons gross and often inaccurate abstractions regarding his life circumstances for more specific and accurate formulations - resulting in increased appropriateness of his behavior, more accurate appraisals offering a much sounder basis for judgment and expectations of others and more reliant on own experience.

Repression of responses: We do not come by our maladjustments, our neuroses or psychoses because of lack of understanding. We learn them through concrete experiences that are hurtful to us - they start early in life and involve us and our relationships with the few important persons in our early life. We understand all too well how it hurts not to be loved, to be denied comfort, deceived, doubted. It hurt when it first happened and it hurts so much now when recalled that we do not permit the recall. Instead we repress, evade, distort, and, in so doing, perpetuate our difficulties with people.

Insight into all this cannot help. The efforts to promote insight can only change behavior by encouraging repression of responses not approved by the therapist, since the client does not want to lose the support of the one person who seems to be on his side. The therapist can help - not by trying to promote understanding, but by making available to the client learning experiences that are as concrete, as immediate, as compelling, as the learning experience that initially started and then nourished his neurotic way of living. The act is more important than the idea - the personal symbol more important than the insight.

Directive and Eclectic Personality Counseling - Thorne.

The term "directive"is unsatisfactory, but it was determined by the conviction that damage could be done by the wholesale use of Rogerian non-directive therapy. Also there is direction in any therapeutic relationship - the therapist is experienced and trained and therefore dominates through prestige. The need for direction is inversely correlated with the patient's potentialities for effective self-regulation. The healthier the personality. the less need for direction - the sicker, the greater the need for direction. Effective therapy often involves a compromise between what a patient sincerely believes he wants and what he needs in the objective judgment of the experienced therapist.

Theoretically it is desirable to depend upon the growth principle, but there are many cases in which the client's resources and growth potentials are so deficient or damaged that adjustment without outside help and direction in impossible. The therapist should make direct interpretations of manifest behavior in the most direct and economical manner possible.

Goal: Establishing suitable conditions for learning to take place and providing suitable training situations according to the psychology of learning so that reconditioning actually takes place and is translated into action. Many psychoanalytic and non-directive techniques can be used in achieving this goal.

Diagnosis is of primary importance: After making a careful diagnosis the therapist must devise and institute suitable training procedures for the correction of the problem.

Thorne concentrates on marshaling patient's intellectual resources, training in self-regulation, reorienting attitudes. Therapy focuses on actual situations, past and present, which have led to current symptoms in the form of infantile reactions, erroneous attitudes, and unhealthy habits of thinking and acting. Techniques, ranging from support and reassurance to disclosure of factual information are used to re-educate patient in the development of more constructive and socially approved attitudes, and the practice of more rewarding behavior patterns.

Although Thorne recognizes the importance of tension release and the establishment of a positive emotional relationship between patient and therapist his chief tool of treatment is the intelligence of the patient, and the appeal is to his reason and self-respect.

COMPARISONS BETWEEN DIRECTIVE, NON-DIRECTIVE, AND ANALYTIC

Expressed feelings: Non-directive clarifies and reflects; analytical interprets feelings before they are expressed or when expressed in disguised forms; directive interprets, but in terms of intellectual content rather than in terms of feelings.

Applicability: Non-directive seems to be limited to those with relatively sound personality structures in which anxiety does not block emergence of positive growth potentials - a patient with serious emotional problems may avoid his anxiety and even choose to retain neurotic defenses.

Directive: when objective is to help withstand anxieties and stresses of everyday life and to use his abilities more effectively; with dependent personalities who are unable to take any decisive action without authoritarian directives; with individual who is endangering himself or others through uncontrolled emotionality; immature individuals who tend to "act out"; those who are sufficiently flexible to alter behavior patterns when their distorted attitudes are brought to their attention and clarified.

Analytic: concerned with investigating and resolving conflicts that underlie distorted attitudes and neurotic behavior patterns and with reorganization of the character structure. Especially applicable to those with whom a transference relationship can be established since this is the main tool - conversion hysterics, anxiety neuroses, some compulsive neuroses and neurotic depressions. Not effective with psychopaths who will not and schizoid personalities who cannot, withstand the symptomatic suffering of the uncovering process and the transference.

Group therapy can be used with any of the above approaches - value is that the multiple relationships with others affords opportunities for expression of feelings, for gaining a sharpened awareness of neurotic patterns, and for constant reality testing for interactions with manifestations of hostility, fear, and abnormal behavior of other members. More effective with patients who have some understanding of themselves and thus are able to see their neurotic patterns in a group setting and make connections between the expression of emotion and its relationship to basic character structure.

Hypnosis: not for non-directive because it involves a relationship in which the therapist imposes his will on the patient; directive - may be used to remove symptoms thru direct suggestions and to obtain abreaction of suppressed feelings; analytic - may stimulate recall of traumatic memories and facilitate the production of associations and related emotions; aid in development and use of the transference relationship when serious resistances are met. However, the repressed material uncovered during hypnosis must also be dealt with in the waking state so that it can become fully integrated with the ego.

POST-FREUDIAN PSYCHOANALYSIS

Object-relations school: (Abraham, Melanie Klein)

Theory: The neurotic behaves as if he had introjected or incorporated objects which had failed to satisfy him in early infancy - the oral period. Emphasis is placed on aggression and the "death-instinct."

Techniques: Search for material during very earliest life of the patient; interpret the very deepest buried impulses and attitudes, without preparing patient for the interpretation.

Cultural school: - 1930's - developed mainly in America although some of the founders were transplanted Europeans such as Horney and Fromm. Sullivan (American) was very influential.

Theory:

1. Interpersonal relations - problems seen as stemming from how the individual relates to others. Horney divided people into three groups - those who move towards others, those who move against others, those who move away from others.

2. Aggression - Fromm who was greatly interested in sociology and anthropology believed that aggression was the product of our society where the caste system had broken down; technology encouraged ambition, but very complex system of laws and conventions made the fulfillment of these ambitions very difficult to achieve - result frustration, leading to aggression.

3. Self-concept - neurotic builds up an unrealistic picture of himself and others - therapy must correct these concepts.

Techniques:

1. Induce patient to talk about behavior and feelings toward the people with whom he comes in contact; to talk about how he sees himself and others.

2. Less emphasis on going back to childhood except to determine when patient began to use undesirable attitudes towards people.

3. Interpretation and dream-interpretation - very important - used to clarify patient's uncounscious attitudes towards people.

Sullivan: Anxiety has a central place in the formation of personality.

Personality is basically formed through interaction with the significant people of early childhood.

Human Needs: 1. Satisfaction of biologic needs and acquired needs.

2. Security - interpersonal need based on the desire for acceptance and approval. This need for security determines the personality development; chief factor in personality's functioning is the attempts to avoid anxiety.

Child's first interpersonal relationship is with the mother - very close, physical - from this he gets pleasure - "euphoria" - if mother is anxious, child experiences unpleasure or loss of euphoria. Later this unpleasure becomes anxiety. He learns that certain behavior is acceptable and certain other behavior is not - tends to mold his life in such a way as to produce the minimum of anxiety. Tends to dissociate completely from the most disturbing aspects of himself - they become the "not me" - the acceptable aspects become the "me". Some of the unacceptable traits are not successfully put out of awareness and are labeled "bad." Acceptable and conscious unacceptable traits become the child's idea of himself - his bulwark against society - he must keep this "idea of himself" unchanged. Any attempts to bring aspects of the "not me" into awareness and include them into the "idea of himself" are anxiety-producing and must be avoided. The more intense the early anxiety experiences, the more rigid the self system.

Fromm disagreed with following theory of Freud: society is a police force created to control man's instincts of sex and destructiveness: therefore, the more civilized the individual becomes, the more frustrated he becomes.

Fromm says that man is the least instinct-ridden of all animals - has fewer ways of reacting at birth than any other creature - he must be taught how to live. Therefore, most of his drives are created by his society, such as lust for power or craving for submission.

Western evolution made man more an individual, with new problems - can no longer rely on static forms of behavior - must learn to think. He becomes aware of his powerlessness in the universe, becomes aware that he must die - feels more alone. Conversely, he has become freer, able to develop his powers more and more, attain greater mastery over nature. His own creations, such as machines, have separated him more and more from nature - loneliness and feeling of alienation result - therefore he strives to return to some form of relatedness to his fellows, even at the cost of giving up some of his individuality - hence authoritarianism, relationships of hate, suffering, exploitation - none of these can be called love but they do save the individual from loneliness.

Personality types:

1. Receptive: developed in a home where parents wish to give and child knows he will receive.

2. Exploitative: developed in a home were things are not freely given, but can be got by taking or manipulating.

3. **Hoarding:** developed in a home where there is a poverty of emotion - child learns to hang on to what he has, because there may not be anything more.

4. **Marketing:** product of capitalistic culture - one whose value of himself is entirely determined by the value placed upon him by others - tries to make himself into whatever the immediate people desire - cultivates traits which increase his sales value and tends to deny aspects of himself which are not saleable.

Authority: 1. rational: genuine, based on competence

2. irrational: based on need for power

First is aimed at freeing the subject, second at keeping him subservient.

Selfishness and self-love: narcissism is a defense against self-hate - based on low self-esteem and always a product of neurotic difficulty.

Sullivan claims that personality is developed thru interaction with others and he does not admit the existence of a unique individual self - says its a delusion. Fromm disagrees - says such a man is self-alienated - that his adjustment and cooperation take the place of genuine relatedness.

Fromm is much more concerned with maturity, capacity for love and productive work, ability to transcend one's culture.

Both say that instinctual drives are relatively weak in the human and not the usual cause of neurotic difficulty.

Horney

Personality - largely determined by the kind of relationships developed with other people - neurotic development results from disturbed human relationships.

Individual has within him a constantly-operating, positive, creative element which works toward genuine, healthy growth.

The neurotic lives with a delicately balanced compromise of compulsive and incompatible elements - when compromise becomes upset or he can't find one, symptoms appear - tension, anxiety, panic - "everything goes to pieces." His world is going to pieces, but he doesn't realize that it isn't worth saving.

AIMS: greater awareness of the present - linking past with the present - patient becomes aware of how and why the past patterns are operating in the present - this leads to genuine insight. He sees that his attitudes, feelings, etc. toward himself and others are incompatible, detrimental to his well-being, and no longer essential. VERY IMPORTANT GOAL - uncover strength presently being used neurotically.

Theory of development of neurotic personality:

Infant - reacts ONLY to physical comfort or discomfort. His needs are personal warmth, reliability, respect for his immaturity.

Child - same needs as above plus justice. If child or infant gets these, he feels loved - therefore SAFE.

Unfavorable psychic conditions: unreliability, inconsistency, overindulgence, oversolicitude, favortism, injustice, unrealistic demands, antagonism, humiliation, cruelty, parents who cannot love without ulterior or false motives. Any of these give child feeling of insecurity - he feels UNSAFE. (Inattention, coldness, remoteness can also give child feeling of unreality.) He feels helpless, abandoned - becomes hostile; his helplessness, isolation, hostility result in basic anxiety which also contributes to his feeling of being unsafe.

To allay ANXIETY he chooses one of the following neurotic trends:

1. move toward people - submissive, obedient
2. move against people - rebellious
3. move away from people - withdrawn

All these trends are present but he chooses one, pushes others into background. All are unsatisfactory and increase strength of the neurosis - (example: submissive child is taken advantage of.)

Primary defenses: He develops several of the following defenses:

1. stresses one set of trends - pushes others underground
2. externalizes his internal problems - blames others or circumstances; focuses on other peoples difficulties or weaknesses.
3. constructs an idealized image of himself
4. detaches himself partially or totally from emotional relationships with others.

Secondary defenses: to support primary defenses, develops -

1. Blind spots - doesn't see contradictions or discrepancies.
2. Rationalization - to explain away inconsistencies.
3. Compartmentalization - behaves one way in public, another in private, etc.
4. Flippancy, cynicism.
5. Claims everything he does and feels in right
6. Elusiveness - becomes devious

Consequences:

1. Uses enormous amount of energy in maintaining defenses.- less energy left for developing healthy capacities, relationships, enjoyment of life; feels tired, futile.

2. Spontaneity, initiative, sustained action difficult; inertia, indecision.

3. False justifications and pretenses - blunted moral values; truth and honesty missing.

4. High egocentricity (even in the self-sacrificing) with resultant arrogance.

5. Hopelessness - caught in conflicts that cannot be resolved; feels doomed to frustration; becomes shadowy and unreal; no notion of what he wants.

6. Despair, resignation and hopelessness may lead to bitterness and rage against fate and others; may become sadistic or destructive.

7. Fears - some sharp, some diffuse; fears exposure, humiliation. Specific fears may become externalized and symbolized.

8. Depression - helpless feeling from conflicts leads to impotent rage; if rage is repressed, depression is diffuse - leads to self-pity; if rage is more conscious, he thinks of suicide.

9. Inability to think, concentrate, make decisions, etc.

10. Disturbed relationships with others - inability to get along, feels excluded. intense shyness or aggressiveness, inability to love or hate, sexual disturbances.

11. Physical manifestations - flushing or pallor, sweating, high or low blood pressure, muscular tensions, gastrointestinal upsets, migraine, etc.

12. Comforting or narcotizing agent (drugs, liquor) originally intended to allay anxiety, becomes habitual, uncontrollable, harmful.

The "successful" neurotic makes what appears to be a good adjustment to life, but there are deficits in character, achievement and relationships - he does not realize much of his potential.

Horney is optimistic in her rejection of instinct theories with their implied fatalism - basic premise: we are not passive agents victimized by unchangeable instinctual conflicts, but rather individuals WITH our culture carrying the responsibility for initiating, aggravating and perpetuating our own disruptive inner conflicts and, at the same time, carrying the capacity to change.

On this premise, authority toward the child stems from love and respect and not from fear and the need to repress and sublimate something considered to be instinctively anti-social.

Therapy should:

1. Be more concerned with the present self-perpetuating elements than with the past.

2. Bring to the patient's awareness a.) his protections against and his denials of his basic conflicts and b.) their intricate and complex interplay, such as self-hatred and moving away from self.

3. With the reactive and vicarious living of the patient, so driven to relieve or avoid anxiety that he has no feeling of his real self.

Unable to develop his own goals and profoundly weakened by basic conflicts, patient builds up an idealized image of himself because he cannot tolerate himself as he actually is. This idealized image becomes an inner tyrannical dictator.

Hypnotherapy

Return of Hypnosis: Starting around 1940 in the U. S., there was a renewed interest in hypnotherapy. It is considered not of permanent psychotherapeutic influence by itself, but effective as a catalyst and, when used, should be in conjunction with specific techniques.

Values:

1. Produces a remarkable relationship in which the hypnotist can make suggestions that are acceptable to the subject which enable him to experience widespread psychic and somatic effects. This is probably based on the fact that the trance symbolically represents a relationship with an idealized parental figure to whom the subject submits and whose suggestions he follows in the hope of winning love, support, etc. It expedites certain authoritarian therapies (reassurance, guidance, persuasion, symptom removal through prestige suggestion.)

2. Tends to modify or to remove repressions that keep certain aspects of the personality from awareness.

Symptom removal through hypnotic suggestion: Rapid and sometimes miraculous. Disadvantages - few persons are susceptible to this approach; effect may vanish and symptom may return in same or altered form; it deals with results rather than causes of an emotional problem. Problems that yield best are those having a minimum defensive or secondary value for patient - hysterical symptoms such as tics, spasms, etc. Habit disorders also may be helped (smoking, nail-biting, insomnia, etc.) Even though symptom removal deals with result and not cause, sometimes the result of some symptoms is so detrimental that subject's life and mobility may be extremely limited and perhaps even threatened; this is the principal value of hypnotic suggestion.

Hypnosis in supportive psychotherapy:

Aim: To bring subject to some sort of emotional equilibrium by overcoming his emotional decompensation as evidenced in anxiety or depression, by remedying his defenses against anxiety, by getting him to adjust to this liabilities, by expanding his assets to the fullest, by overcoming remedial elements in his environment, by helping him adjust to irremediable elements, by executing to the full his existing creative capacities.

Hypnosis can be used in conjunction with guidance, reassurance, persuasion, desensitization, and re-education. Where psychological analysis is impractical or impossible, persuasive therapy provides him with a mental crutch. The substitution of persuasive philosophical precepts for destructive habits is probably the lesser of two evil$. Some obsessive-compulsives do very well with persuasion, sometimes better with analysis. In persuasion guidance and reassurance, an effort should always be made to bring about a change in the relationship from directiveness to non-directiveness, and to work with the dynamic roots of the patient's problems in an analytic way whenever possible so that he may obtain insight into his difficulties and a better understanding of himself.

Hypnoanalysis: Most important determinants of behavior are unconscious. Aim is to bring awareness repressed elements of the personality, to show the individual how his impulses and drives create symptoms, to show him the functions of his drives, and to explore their purpose and genetic origins.

Goal: Drastic re-organization of the personality structure, liberation of the self from conscience standards that contain introjected early disciplines, bringing the ego to a mature level of integration at which it can express basic biologic and social needs in conformity with the group. Unfortunately, the individual always seeks to maintain his status quo, to resist change.

Hypnosis exerts a striking influence on the resolution of resistance. Sometimes a trance is enough. Usually, however, special techniques are needed - free association, dream induction, automatic writing, hypnotic drawing, play therapy, dramatic acting-out, regression and revivification, mirror-gazing, and tne induction of experimental conflicts. Most important are dream induction, free association, regression and revivification.

Hypnoanalysis may be employed in

1. Development of a transference neurosis
2. Producing desensitization (in which patient is helped to become aware of and to adjust to repressed elements in his personality)
3. Re-education through analytic insight

In 2. and 3. neurotic transference is avoided as much as possible.

Desensitization in hypnoanalysis: The objective is to help the patient become aware of memories and conflicts, and to deal constructively with the associated emotions. It is especially useful in hysterical conditions and traumatic neuroses.

Mere recall changes NOTHING in the basic character structure - the only thing that changes is that he is liberated from some of the effects (symptoms) of repression, and the influences of his conflict and its associated emotions. Through interpretation the therapist confronts the patient's conscious ego with the implications of his repression. At first the ego may be unable to accept the repressed material - he may deny its validity. However, as the conflicts or memories are brought up in increasingly-undisguised forms, the ego becomes inured to their influence and the patient becomes more capable of accepting them as part of himself. Since the material is intensely traumatic, the patient is urged to remember only these aspects of it that he can tolerate.

Results: Recall of the event and especially the accompanying catharsis of the associated emotion usually make the symptoms no longer necessary. However, there does not seem to be any permanent influence. The patient is not motivated to pursue further exploration into his present interpersonal patterns, unless the therapist can convince him of the value of further work.

Re-education in hypnoanalysis: The therapist attempts to bring the patient to an understanding of the dynamic sources of his difficulty, the meaning of his symptoms being demonstrated to him in terms of repressed conflict. Thus he is brought to an awareness of his conflicts, their influence on his present adjustment, their origin, and finally the ways in which his prevailing attitudes and patterns of behavior may be modified toward a more realistic and productive adaption. The medium is the relationship with the therapist, keeping transference at a minimum. Insight is achieved by an appeal to the intelligent, constructive forces of his personality. The therapist must be accepted as a benevolent authority, hostility and other irrational emotions must be kept as realistic as possible.

GROUP PSYCHOTHERAPY

Group work was used by many schools including Mesmer and Coue. In 1905 a Boston doctor started personal hygiene classes for his tuberculosis patients at a clinic - found them to be not only educational but effective in raising morale and contributing to recovery. He and others extended this method to other chronic disorders and the educational classes developed into therapeutic sessions. Some of these began with relaxation exercises and were called "thought-control" clinics.

Didactic groups: During the first World War Lazell in Washington found that psychotic patients, inaccessible to individual treatment, improved greatly in groups where simplified lectures were given. Dr. Marsh in New York did the same, widening the variety of topics and having the patient engage in group activities such as community singing, committees, etc. Klapman, mostly with psychotics in hospitals, lectured on mental illness, case-histories, and wide range of other subjects. Also he had patients write autobiographies.

Adler's Groups: Started with child guidance clinics in 1921 where he interviewed the child and its parents in the presence of other parents, children, and teachers. He felt that this procedure would suggest to the child that his trouble was not a private affair and that others were interested in him.

Therapeutic Communities: Bierer (Adlerian) in England, combined psychotherapy with communal activities for the entire day - patients were encouraged to work out rules amongst themselves.

Interview Groups: (or "group analytic therapy") - main technique of modern group psychotherapy. Developed rapidly during 2nd World War. Regular meetings of the same group of patients under the guidance of the same therapist. Patients are encouraged to talk to each other about their symptoms, personal difficulties, and emotional conflicts. They are also encouraged to help interpret the feelings of other members. Patients learn to understand and accept emotional reactions of others and themselves, learn that others may have similar problems, etc. Usually patients have some individual therapy first. Some therapists group patients according to illness, type of problem, sex, age, and other classifications.

Non-directive Groups: Group consists of about 6 clients, rough age groupings, separate groups for psychotics, occasional special interest groups. They meet twice weekly for about 1 hour, membership does not change, each member is interviewed first, and most groups meet for 15 to 30 sessions.

The therapist must be the kind of person who is thoroughly accepting, sensitive to the feelings of others, able to communicate his understanding to them, free from urges to direct the group because of his needs , and have confidence that the group and its individuals can find their own best direction.

He tries to bring into action the therapeutic influence of the group itself. At first he must do almost all of the therapy, but be ready to let others take over, contributing when important feelings are not picked up or when conflict among members threatens. An effective group therapist is one who can maintain a minimum level of anxiety while encouraging members to take over. Most important factor is that members feel free from threat and be able to examine themselves openly in a safe atmosphere.

Progression and change: Findings: An increase in permissive and accepting behavior, a decrease in critical, evaluative, and interpretive behavior. At the beginning, each member seems to be almost totally involved with his own problems. Gradually he becomes less anxious, more aware of, then interested in, then helpful with, others. Expressions of insight, of positive planning, of positive attitudes, toward the self and others showed marked increase.

Psychodrama: Moreno in Vienna, after the first World War, started the "Theatre of Spontaneity". Instead of professional actors, he called for volunteers from an audience to enact scenes from their own "private worlds." His original purpose was to free the theatre from its traditional formalism, but he began to see that this activity gave the individual an opportunity to portray his personal problems, conflicts, etc. and achieve a catharsis. He came to the U.S. in 1927 and, in 1936 founded a sanitarium where he developed his techniques. Trained assistants play other parts in the psychodrama, other patients form the audience and are encouraged to discuss or participate in what goes on.

Moreno's orientation is existential - analysis of existence, new evaluation of the encounter, emphasis on the moment of action.

Spontaneity - creativity is the primary problem of psychotherapy. It is the central place in the formation of the self. Insight is NOT the major goal, but rather the ability to become spontaneous - learning through experiencing. Emphasis is placed on aiding the individual to develop a realization of himself, of all his facades, in a setting where he feels safer from judgments than he does in his outside environment.

Encounter (Begegnung) - the sum total of interaction - of great importance in helping individual free himself.

Anxiety - traumas accentuate or intensify, but do NOT produce anxiety - the origin of anxiety is the separation of the individual from the rest of the universe - he feels cut off, helpless, threatened by death - Begegnung tries to restore individual's union with the universe.

ACTION is vital to biologic life, mental life, and interpersonal relationships; instincts demand expression, excitement needs discharge.

There is no "oral," "anal," etc., zone - instead there is a zone which consists of various parts of the individual and his environment which meet and form a gestalt.

Group psychotherapy - means exactly that - therapy of the group rather than the individual, although actually individuals often do get solo therapy within a group. Interaction with others in the group is of the greatest value although lectures, interviews, analysis, interpretation are also useful.

Group should be composed of cross-section in miniature of the community in which the group lives and should function as a miniature society or universe within which all members are accepted and find opportunities for expression.

Patient-physician relationship is no longer the cornerstone of therapy - the crucial participants are the patients in the group; the therapist is only a member of the group with a special and important function within it.

Psychodrama - group psychotherapy with its conversation, interviews, analysis, insight, etc. is not enough - therefore psychodrama is used as a vehicle for the acting out of problems in a setting removed from reality, and where participants feel safe. It is a therapeutic acting-out in a controlled environment as a prevention measure against irrational acting-out in life. It aids the individual to actualize that part of his past life which he needs to re-experience - to most situations which he has never fully faced.

Psychodrama is based primarily upon concepts derived from analytic approach. Primary contribution - role playing, in which the patient spontaneously acts out his problems in dramatic form with other actors and with the therapist as director. Patient is stimulated to give full expression to his feelings and attitudes and thus achieve catharsis and desensitization. The resolution of deeper problems and conflicts is further advanced in his relationship to the other actors and the director. Used within the context of a directive approach - especially effective with patients who have a good deal of generalized inhibition.

Agents - chief therapist, professional auxiliary therapists and patient-therapists.

Method - patient is encouraged to choose a situation which he will act out - if he has difficulty, chief therapist suggests a problem in patient's home or job situation. Patient assigns auxiliaries to various roles and gives them information on roles they are to play - if possible, he enacts as thoroughly as possible these roles in order to give auxiliaries full understanding of them. He is asked to duplicate with as much detail as he can, the situation he has chosen to portray.

TECHNIQUES:

1. Cluster warm-up - group naturally tends to break up into clusters, each cluster talking about something - they may group and regroup - out of this, someone makes a strong statement pertaining to his personal response or involvement in what his cluster is discussing - he becomes the "star".

2. Specific problem is suggested by therapist, assistant or member of the group, roles are assigned. This is called the directive warm-up.

3. Spontaneous improvisation - patient acts in fictitious roles.

4. Role-reversal.

5. The double - auxiliary plays the same role portrayed by the "star" - sometimes he can verbalize or act out what he believes the "star" is feeling or thinking, but is too frozen to express.

6. Soliloquy - patient and auxiliary are assigned fictitious roles - they are encouraged to interrupt their role-playing with interactions between their real selves.

7. The mirror - auxiliary mirrors "star".

8. Dream enactment.

9. Interpretation - can be made by therapist, auxiliary, or members of the group.

Play Groups - Slavson in 1934, working with problem children in New York had groups of children play freely together under the charge of a therapist who interfered minimally. Claimed this had diagnostic and therapeutic value. Children too frightened or aggressive to derive value from the "play groups" were placed in groups where the therapist exercised more control over the activities and encouraged the children to express their violent feelings in talking rather than action - called "activity-interview: groups.

Therapist is not a leader, but the center of emotional cathexis. Members follow their own lines of interest. There is no common plan - each patient achieves catharsis and insight thru his own effort and by means peculiar to himself. Group is fluid, has little organization, seems to have no aim, direction or purpose, but all members have the purpose of correcting psychological distortions within himself and seeking his own improvement as a separate entity - there is no group aim.

Dynamics: interstimulation, interaction, induction, neutralization, identification, rivalry and projection. There is little cohesiveness - patients remain self-absorbed and preoccupied with their own problems. Group cohesion occurs seldom and when it does, it is temporary.

Therapist must be continually aware of the state and needs of each member of the group.

Suitability of patients for group therapy:

Patients who are inaccessible to treatment because of organic or constitutional defects, severity of problem, extreme regression, or excessive resistance may have to be excluded from groups.

Not all patients can be treated together - not all patients can respond to group - some patients may be traumatized if exposed to such direct interaction with others. No one type of therapy is effective with all patients.

Suitable for group treatment: Adolescent girls, even with serious emotional problems (if they can accept and participate in groups), patients who have anxiety and symptom neuroses, especially conversion, those with weak ego development, those with infantile personalities, confused (sexual) identification, ideological confusion without intense disturbances.

Non-suitability of patients for group therapy: Psychopathy, narcissism, obsessional and compulsive states, hallucinations, character neuroses, Idealogical confusion with intense distrubances, strong and uncontrollable need to act out in behavior or speech, calls for individual psychotherapy before group work.

Group composition: One unsuitable patient can block the group's work, avoid density of pathology and aggression. Too many intensely disturbed patients can re-enforce one another and create unmanageable tensions. Some patients should be neutralizers - those who dilute emotional tensions and show self-control; rage, anger, distress, self-pity are infectious - too much can prove too disturbing for the group; there should be enough variety of personalities and problems so as to avoid too great re-enforcement and over-intensification. Patients should catalyze one another.

Dynamics factors in analytic group therapy: Relationship, catharsis, insight, ego-strengthening, reality testing and sublimation. Often the release of inhibited or repressed hostile impulses will effect some sort of improvement.

When the patient, at the first interview, shows considerable anxiety, investigatory work is counter-indicated. The intensity will have to be diminished before the patient will be able to look at himself at even a short distance, let alone permit himself to feel and observe himself. Sometimes a few leading questions will allay the anxiety. Some patients, however, will interpret neutral questions as meaning the therapist is disinterested. If the therapist lets the patient go from one point to another, anxiety may be increased - this patient is looking for someone to take control. Sometimes systematic and chronological questioning will lessen his anxiety.

The ultimate aim of ideal treatment is to remove the defenses that have become pathogenic, leaving as little scar as possible. However, often a defense needs to be increased or strengthened and the symptom can be modified so that it no longer bothers the patient.

Helpful therapy entails a recognition of the relative strength and weakness of various drives and defenses. The therapist should be able to gauge when the patient can or cannot tolerate the investigation of his hostile impulses, when a hysterical patient may tolerate ventialation of his anxiety, when a schizophrenic may need reassurance and strengthening before his anxiety can be touched.

SUGGESTION AND CONDITIONING

About 1860 Liebault founded a clinic where he conducted experiements in hypnotic suggestion. Coue, a chemist shop owner, noted that certain drugs had beneficial effects, even though there was no physiological justification - he became convinced of the power of "imagination." He studied the techniques of hypnotic therapy under Liebault, made his own modifications, and in 1910, opened his own free clinic. He did not use hypnotic suggestion but did resort to tricks which would convince the patient that Coue had unusual powers. His beneficial results, like those of hypnotic suggestion, tended to wear off with time so he devised auto-suggestion which increased the effectiveness of the results.

Pavlov and behaviorism had tremendous effects on Soviet psychotherapy which includes:

1. Direct appeal to rational consciousness by means of logic, persuasion, scientific enlightenment, group pressures, and positive incentives.

2. Re-inforcement of positive influences through suggestion and, occasionally, hypnosis.

3. Removal of patient from harmful influences - involving him in wholesome experiences and activities, especially work activities.

PRESENT-DAY PSYCHOANALYTIC THERAPY:

Assumptions: Neurosis develops from the repression of vital experiences with important parental agencies, experiences centered around oral, anal, and Oedipal stages. Such repression is promoted by fear of the loss of love, or fear of punishment from parents, which has been internalized in the superego. Current thought is centered more on the meaning of these experiences to the patient, on the relationships to present events and to the defense mechanisms of the character structure, than on the mere discovery of sexual trauma.

Therapy: Focuses on bringing to conscious awareness derivatives of the repressed experiences and, through relationship with the therapist, the ego of the patient is strengthened to the point where he can withstand the anxiety associated with this repressed material. Primary diagnostic materials are free association and dreams. In the process of therapy, the patient must recognize and understand the repressed material as derivatives, in an attenuated from, of early fears and conflicts. To accomplish this, the therapist deals with the resistance and defenses of the adult character structure.

The most important technique is the transference relationship - the patient relates to a new parent figure (the therapist) and "acts out" his neurotic feelings and attitudes derived from experiences during his developmental period.

By means of strategically timed interpretations, the therapist exposes the nature of the transference as well as the defenses that the patient has used to perpetuate his neurosis. He helps the patient make connections between past and current events and to work through his problems by seeing how they condition every aspect of his life.

Usual term: 4 or 5 sessions weekly, 2 to 5 years.

Briefer psychoanalytic therapy: The therapist takes a more active role, may also use hypnosis and group therapy. Greater emphasis is placed on diagnosis so the therapist can focus interviews on significant material and manipulate the transference relationship by assuming roles in accordance with the patient's needs. The therapist may use various means to bring unconscious conflicts to awareness, deal with resistances, and control certain aspects of the transference relationship.

GENERAL REMARKS

There are two broad types of psychotherapy - supportive (direct assistance through persuasion, suggestion, relaxation, reassurance, etc.) and reconstructive (attempt to re-organize permanently the patient's personality structure.)

Goals of the various schools vary widely from relieving symptoms to improving interpersonal relationships, from increasing self-confidence and reality-facing to adjustment to the demands of society; increasing self-awareness, freedom of self, maximum development of potentialities.

No single approach is pertinent to all individuals. Strict adherence to one school causes grave errors - client at first may need ventilation, reassurance, and other supportive measures before he begins to feel the need for more intensive probing of his personality structure. With his changing needs and change in orientation to his problem, the techniques used by the therapist also need to be changed if patient is to derive maximum benefit from the therapy.

THE NEUROTIC

All schools agree that the neurotic is a person whose inner balance is disturbed, but they disagree as to dynamics:

Freud - difficulties of sexual development must be resolved

Adler - egocentric inferiority-superiority drive must be overcome by adjusting to society

Rank - uniqueness and independence of the individual must be established through creativeness and assertion of his own will

Jung - inner structure of the soul must be harmonized

Sullivan and Horney - relationship difficulties with others must be resolved

RECENT DEVELOPMENTS
IN THE
FIELD OF PSYCHOLOGY

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RECENT DEVELOPMENTS IN THE FIELD OF PSYCHOLOGY

The first two forces in psychology were behaviorism and psychoanalysis, in that order. The psychologists who advocated behaviorist theory were increasingly active during the last century and their main concern was with studying "man" as though he were made up of many parts. They focused on studying each part -- his actions, reactions, personality traits, patterns of behavior, learning, adaptation, and many other fragments of a "man."

One of their primary hypotheses was that a man was similar in many, many respects to various animals and, in order to find out how a human being functions, much study was done with rats, pigeons, dogs, etc. The assumption was that if an animal behaves in a certain way under certain circumstances, a man will do the same, or something like the same.

Along with this fragmentation of man for the purpose of study, the Industrial Revolution was occurring, which resulted in the loss of individuality for the individual -- he became a cog in a machine, a part of a nameless and dehumanized mass of other beings, and he was treated in this fashion by the psychologists and the governmental powers.

Some very great thinkers became alarmed about what was happening in these very strong forces which were dehumanizing man. Among these thinkers were several clergymen who began to make their alarms known, although few people listened to them. These men were the forerunners of what is now known as "Humanistic Psychology."

The next psychological force which appeared was psychoanalysis, a vast and complicated body of theory formulated by Sigmund Freud. There were many facets in his theories -- one of the most influential being that a person is primarily the product of his early years. He is shaped and molded by the important people (usually his parents, principally his mother) in the first few years of his life. From that point on, he will respond to other people in the same way he reacted to his parents and, in most cases, it will be very difficult or perhaps impossible for him to change unless he undergoes intensive and prolonged therapy.

During the latter part of the last century and the beginning of this one, a few voices were heard disagreeing with the theories of Behaviorism and Psychoanalysis. However, these voices were few and unheeded. Not until the last 20 or 30 years has there been any appreciable increase in the numbers and strength of those who believed that man is more than his separate parts, his reactions, and his early formative years. This group of people is now many and they constitute what is called the Third Force in psychology. They see an individual as greater than the sum of his parts, than his reactions, and potentially greater than what appear to be his limits.

In 1961, these people came together and formed the American Association for Humanistic Psychology. The movement gathered momentum; psychologists, social scientists, and others in other parts of the world became interested and enthusiastic, and now the association is international.

This association is committed to the fundamental uniqueness and importance of human life. Its aim is to study such areas as love, creativity, growth, warmth, play, self-discovery, self-responsibility, meaning, courage, self-actualization, spontaneity, and peak experiences.

Many brilliant Americans have been exploring some of the above areas. One of the outstanding contributors was Abraham Maslow who has done much valuable work in the field. One of the questions that he posed was, "Why have my colleagues been chiefly interested in the psychology of mental ill-health, the study of the sick and disturbed? Why has there been so little study of the psychology of the mentally and emotionally healthy person?" He believed that if someone could do this, he might discover goals toward which we could strive -- goals which would make us more fully functioning, more happy, and more useful to mankind.

With that in mind, he made an intensive search for those people, past or present, who seemed to lead full, rewarding, and happy lives. He called these individuals "self-actualized" -- meaning that they seemed to have actualized themselves to the fullest or almost to the fullest extent. He studied them in detail, trying to find the qualities they had in common with each other, and this study has been of enormous value.

There is now a Fourth Force emerging, called Transpersonal Psychology. This force is concerned with ultimate states of being, and assumes that man's tendencies toward ultimate meaning cannot be reduced to lower animal drives. The individuals who are involved in Transpersonal Psychology study areas such as wonder, bliss, self-transcendence (rising above oneself), ultimate meaning, and mysticism. From the latter two items, it can be seen that they are delving into philosophical and religious spheres.

EXISTENTIAL PSYCHOLOGY

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EXISTENTIAL PSYCHOLOGY

ROLLO MAY

Reality is not abstract thought, theories, etc., but experience as men live it.

Existentialism means centering upon the EXISTING person -- it is the emphasis on the human being as he is emerging, becoming. The opposite view sees human beings in terms of forces, drives, conditioned reflexes, etc.

The more accurately you describe a given mechanism, the more you lose the person who has the mechanism.

Modern science tends to make man over into the image of the machine and thus dehumanize him.

"Being" is the individual's unique pattern of potentialities. The "unconscious" is not a reservoir of impulses, thoughts, and wishes that are unacceptable to the individual or to his culture, but rather *those potentialities for knowing and experiencing that he cannot or will not actualize.*

Anxiety arises not so much out of fear of insecurity or unfulfilled satisfactions, but rather out of one's fear of one's own powers, and the conflicts that arise from that fear.

The underlying structure of a man is much greater than the sum total of all his mechanisms, forces, drives, etc. This structure is his *pattern of potentiality.*

No matter how great the forces victimizing a man, he has the capacity to KNOW that he is being victimized, and thus to decide how he will RELATE to his fate. He never loses the power to take some stand, to make some decision.

To achieve individuality, man must face the conflicting realities of our world -- face and meet them directly.

A. H. MASLOW

We are faced with the total collapse of all sources of values outside the individual. Political democracy and economic prosperity do not in themselves solve any of the basic problems. There is no place else but inward, to the self, as the source of values.

The authentic person not only transcends himself, but also his culture and his society.

Verbal, analytical rationality is very limited. Raw experience is much more basic and important.

The future is unknown -- therefore all habits, defenses, etc., are of doubtful value because they are based on past experience. Only the flexibly creative person can really manage future, only the one who can face novelty with confidence and without fear. Defenses are tricks used to avoid the anxiety of novelty by pretending or assuming the future will be like the past.

What we call normal or average today is characterized by a general phoniness, a living by illusion and fear -- and seen through the eyes of existentialism, is sickness. The loss of illusions and the discovery of one's identity, though painful at first, can be ultimately exhilarating and strengthening.

HERMAN FEIFEL -- DEATH

Death is something that happens to each one of us. Even before its arrival, it is an absent presence. It is near the center of the human condition -- an essential part, rather than the mere end of life.

Only by integrating the concept of death into the self does a genuine existence become possible. The price for denying it is undefined anxiety and self-alienation. To completely understand himself, man must become aware of a personal death. Life is not comprehended truly or lived fully unless the idea of death is grappled with honestly.

GERALD SYKES (FROM THE HIDDEN REMNANT)

Anxiety and guilt are implicit in man's condition, rather than primarily neurotic. Existentialism was a protest against the way human beings were compartmentalized by rationalism during the 19th and 20th centuries. This kind of rationalism results in self-estrangement. The existentialists protested against the tendency to treat man as an object to be calculated and controlled, made into anonymous units to fit like robots into the vast industrial and political collectivisms of our day.

Anxiety, guilt, death, despair and meaninglessness are inherent in the nature of man and must be faced squarely, as inescapable parts of life. Only when we face them with courage and clarity can we hope for real joy or real solidity or achievement -- unless we prefer well-adjusted conformity and its rewards, together with the neurosis and self-deception that hide beneath it.

In trying to gain power over nature, man has become estranged from it. The result is a vague despair of gaining any real relationship with the natural world, including one's own body.

CREATIVITY, DEFENSE MECHANISMS, AND NEUROTIC BEHAVIOR

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SUGGESTED READING

Self-Analysis	Karen Horney
Neurosis and Human Growth	Karen Horney
The Mature Mind	Harry Overstreet
The Neurotic Personality of our Time	Karen Horney
Understanding Fear	Bonaro Overstreet
The Art of Loving	Erich Fromm
The Transparent Self	Sidney M. Jourard
On Becoming a Person	Carl Rogers
Toward a Psychology of Being	Abraham Maslow
Levels of Knowing and Existence	Harry L. Weinberg
Games People Play	Eric Berne
A Guide to Rational Living in an Irrational World	Albert Ellis and Robert Harper.

CREATIVITY: Whenever we help to bring about, either in ourselves or in others, a change in the direction of further growth, we are being creative.

CHILDHOOD BLOCK TO CREATIVITY: The child starts by being completely dependent on others. When he begins to assert himself with his first feelings of "self" or "I am a separate individual," his expressions and behavior are likely to seem belligerent or rebellious and usually he is "put in his place." His "self" or uniqueness as a particular individual is squelched rather than given room and direction to grow.

HEALTHY PERSONALITY

1. Absence of anxiety
2. Realistic evaluation of oneself and one's environment
3. Realistic values
4. Good interpersonal relationships
5. Ability to love and have empathy for others
6. Flexibility - ability to accept and adapt to change
7. Emotional independence - no need for emotional support from others
8. Respect for oneself and others
9. Acceptance of self and others (including shortcoming and mistakes)
10. Ability to accept frustration and disappointment
11. Sense of individuality - capable of conforming to the norms of society, and, at the same time, capable of deciding when it would be undesirable to conform.
12. A sense of independence - ability to work toward own goals without being constantly concerned about what others may think or say
13. A sense of responsibility - taking into account the consequences of own actions and being sensitive and responsive to the needs of others
14. Realistic goals
15. Personal values and philosophy of life
16. Problem-solving attitude

DEFENDING AGAINST FEELINGS OF INADEQUACY AND INSECURITY

DEFENSE MECHANISMS (First line of Defence)

Defense mechanisms are used to guard against feelings of inadequacy, rejection, failure, frustration arising from inability to solve a problem or satisfy a need, impaired self-esteem, feelings of guilt and anxiety.

To overcome these disturbing feelings we may accept the failure or rejection; we may try to solve the problem or satisfy the need through renewed efforts; OR we may resort to defense mechanisms.

A defense mechanism is a means of DENYING THE REALITY of failure or frustration (and the accompanying unpleasantness) by overlooking or ignoring it and replacing it with something else.

A defense mechanism is an ego-sparing or anxiety-relieving alibi that attempts to explain away failure - it is always SELF-DELUDING. All people use them to some degree, but when they become a way of life, the individual becomes maladjusted.

VALUES OF DEFENSE MECHANISMS: Preserve self-esteem, protect against self-devaluation and anxiety. May work satisfactorily until the mechanism becomes exaggerated to the point where it defeats its purpose.

1. Compensation: Trying to offset a real or imaginary defect in one area by substituting a skill or quality in another; covering up a weakness by substituting another trait: over-gratifying a need or desire in one area to make up for frustration in another.

2. Rationalization (sour grapes): Converting the unattainable into the undesirable; trying to justify behavior, beliefs, inconsistencies, failures, etc. by blaming circumstances, tools, other people, etc.

3. Identification: Person who cannot achieve his own goals (or has none), tries to enhance his self-esteem by identifying himself with another person or a group, hoping to share their achievements or fame.

4. Projection: Assigning to others those characteristics, thoughts, desires, feelings, etc. which we cannot tolerate in ourselves; blaming others for own shortcomings and mistakes.

5. Daydreaming: Gratifying frustrated desires in imaginary achievements, withdrawing from reality into a private dream world that protects one from the threat and anxiety of unsolved problems and disturbing situations.

6. Withdrawal: Removing oneself physically from the disturbing situation.

7. Repression: Unconsciously preventing dangerous thoughts and impulses from entering awareness.

8. Regression: Retreating to earlier, less mature forms of behavior; psychological retreat into the past to escape from present threats or conflicts.

9. Conversion: Instinctive and unacceptable wishes turned into physical illness or symptoms, which can protect against humiliating memories and feelings.

10. **Displacement:** Shifting of emotion, usually hostile, from the person or situation with which the emotion was originally connected, to another safer person or situation.

11. **Introjection:** Adopting the behavior, standards, values, or attitudes of others, in order to make these other people less threatening.

12. **Sublimation:** Substituting socially-accepted means of satisfying impulses for socially-unacceptable means.

13. **Reaction Formation:** Behaving ina way that is the opposite of that which the individual feels; compensating for negative impulses by substituting behavior that will best mask these impulses.

DEFENSE MECHANISMS ARE UNDESIRABLE WHEN they jeopardize the physical or mental welfare and growth of the individual or of society. They cease being adjustive when they obscure the source of a conflict or the real nature of a problem, when they lead to cumulative maladaptations, when they prevent a person from making an objective analysis of himself in relation to his problem and blind him to the possibility of alternative courses of action.

THE NEUROSES (Second line of Defense)

If the first line of defense, the defense mechanisms, cannot sufficiently protect against feelings of insecurity and inadequacy, we may mobilize a second line of defense - the neuroses. These are disorders reflected in ways of thinking, feeling, and behaving, produced by severe emotional tensions that the defense mechanisms could not adequately control.

Neurotic symptoms are attempts to cope with inner conflicts and out pressures that are threatening. (Defense mechanisms may continue to be used in neurotic behavior.)

NEUROTIC BEHAVIOR: unconscious, inappropriate, rigid; not endangering or requiring hospitalization. The neurotic is in touch with reality, recognizes the inappropriateness of his behavior, but doesn't understand it, and has disturbed relationships with others.

1. Anxiety reactions: Difficulty with breathing, heart palpitations, sweating, mouth-dryness, dizziness; may be a chronic state of fear or temporary attacks of intense fear.

2. Phobic reactions: Adopting an unreal outside danger, which causes less pain and anxiety than an unconsciously-feared internal danger. This is usually a danger left over from childhood, the memory of which has been deeply buried because of the fear of punishment for thinking or doing something taboo. The fear becomes exaggerated and illogical and attaches to a specific person(s), object(s), or situation(s).

3. Obsessive-compulsive reactions:

   Obsession: persistent repetition of a disquieting, unwanted thought.
   Compulsion: an act performed without knowing why or without con-

sciously wishing to do it.

4. Dissociate reactions: thinking, feeling and behaving become separate from consciousness and function as separate activities.

   a. amnesia - may be partial or total
   b. fugue (flight) - prolonged period of amnesia during which the person usually leaves home and job and beings a new life with a new name and identity.
   c. multiple personality (Jekyll-Hyde) - individual cannot integrate his contradictory traits or his various roles.

5. Conversion reactions: anxiety and emotional conflict are converted into physical symptoms of disease or disability.

   a. hysterical sensory disturbances - deafness, blindness, etc.
   b. hysterical paralysis - limbs, voice, any part of the body
   c. motor disturbances - loss of muscular control, tics, tremors, etc.

6. Repressive reactions: withdrawal from stimulation, lack of interest, loss of initiative, feelings of hopelessness or worthlessness, self-doubt; dejection, pessimism, discouragement.

7. Hypochondriac and neurasthenic reactions: extreme preoccupation with how one feels physically.

   a. hypochondria: concern over digestion, heart, lung, etc. difficulties.
   b. neurasthenia: feelings of being tired, exhausted, weak, cannot concentrate, easily upset by difficulties, very irritable.

   Both of these provide a "physical" excsue for not trying things which may fail - both are protection against the admission of inadequacy or failure.

CAUSES OF NEUROTIC BEHAVIOR:

1. Heredity: difficult to differentiate between inherited and acquired characteristics - assumption is that it is "learned" behavior.

2. Past experiences: experiences from earliest childhood help to shape the way we think, feel and behave, and so influence our behavior toward normality or neuroticism. In addition, certain specific experiences may promote defensive, maladaptive, or neurotic behavior. A child who has had considerable illness may, in times of stress, fall back on illness and physical complaints in trying to solve his problems; overstrict training in cleanliness, punctuality, rules, etc. may result in obsessive-compulsive behavior; rejection may result in a person's wanting love or attention intensely but avoiding it in order to avoid another rejection.

3. Contemporary situations: an individual may function quite adequately unless special stress or pressure appears - serious quarrel, serious financial problem, loss of job, war, etc.

FUNCTIONS SERVED BY NEUROTIC BEHAVIOR

Neurotic behavior patterns are unconscious attempts to deal with conflict situations, ways of dealing with anxiety and conflict. The neurotic cannot find relief from anxiety through normal and acceptable channels. Neurotic complaints may protect a person from taking on problems that are beyond his ability - he shifts the responsibility for his failure or inadequacy to some physical defect over which he cannot be expected to have any control, and thus maintains his self-respect; the guilt-ridden person who has a hand-washing compulsion does not really free himself from his guilt feelings, but he does reduce them temporarily.

Although it does reduce tension temporarily, neurotic behavior may at the same time aggravate the underlying causes of the tension - a person who does not get along well with others may alienate them further by compulsive or obsessive behavior.

BECOMING A PERSON

1. Develop an awareness of self - become CONSCIOUS of self. This is not self-consciousness (which implies standing outside oneself, looking at oneself, and usually criticizing oneself.) Consciousness of self makes for spontaneity - self-consciousness breeds inhibition, excessive control, etc.

    a. Rediscover, clarify, and accept one's feelings. Many feelings are considered non-acceptable - two most strongly disapproved of are RESENTMENT and HATRED. When a child's freedom is interfered with, he becomes resentful - if he is not permitted to express his resentment, it becomes bottled - up - usually develops into hate - both feelings often become buried as he feels it is dangerous to have these feelings toward people he needs.

    b. Rediscover one's body and body sensations.

    c. Discover and identify with subconscious aspects of oneself as comfortably as possible - be sympathetic and accepting of expressions of one's dreams. First step toward utilizing the potential of the subconscious is to become aware of one's resentment - to accept and feel it. This does not mean to ACT on it -- merely to EXPERIENCE it.

    d. Develop the objectivity that enables us to study ourselves critically and dispassionately, with a minimum of self-deception and camouflage - what motivates us, how we communicate with others, how sensitive we are to the needs of others, how certain conditions affect our emotional ups and downs. Become aware of strong points so as to utilize them to better advantage, discover weak points and habits which are inappropriate and do not solve problems; how we affect our environment and how it affects us, own needs, desires, ways of doing things.

All of the foregoing lead to experiencing oneself - then one finds the answer to "what do I want," "what is important to me," etc., instead of "what SHOULD I want,", "what is important to the neighbors," etc.

2. Try to heighten perception of the environment and other people. Aim for sensitivity to the needs and feelings of others, notice how people behave under certain conditions. Acceptance of others (and self), including shortcomings and mistakes, is fundamental in the ability to love.

HORNEY'S THEORY OF NEUROSIS:

The foundations of neurosis are laid in childhood when, due to influences from an unfavorable environment, the individual is beset by pervading anxiety and by feelings of helplessness and isolation in a hostile world. His contact with others is then not sufficiently free for him to express his real feelings. He is primarily concerned with lessening his feelings of anxiety and his behavior and contacts will reflect this.

The result is that his basic drives, which in the healthy individual serve real interests, become compulsive reactions aimed at lessening his feeling of anxiety, without regard for real wants and interests. As the individual grows in years, the neurosis grows with him, unless corrective steps are taken.

Each main component of his basic anxiety generates a protective compulsive drive. The helplessness leads to a compulsive need for affection; the feeling of hostility in the environment is counteracted by a need to dominate; the feeling of isolation leads to a protective withdrawal, a moving away from people and from awareness of emotional conflicts. Since these activities are incompatible, they give rise to a basic conflict.

He is then caught in a network of defenses which operates automatically and unconsciously. Consequently much of his energy is used to support a system which obstructs his fuller living and deprives him of available forces. The ensuing impoverishment of his personality brings about self-contempt, compensatory strivings in the form of living in fantasy in order to maintain a flattering picture of himself, and a diffuse envy and hostility toward others.

EXISTENTIAL THEORY OF NEUROSIS:

Anxiety and guilt are implicit in man's condition, rather than primarily neurotic. Every person is centered in himself and an attack on this center is an attack on his existence itself. Neurosis is not a deviation from our theories of what a person should be, but rather the method a person uses to preserve his own center, his own existence.

His symptoms are ways of shrinking the range of his world in order that the centeredness of his existence may be protected from threat, a way of blocking off aspects of the environment so that he may then be adequate to the remainder.

Neurosis is an ADJUSTMENT, and that is just its trouble. It is a necessary adjustment by which centeredness can be preserved - a way of accepting non-being in order that some little being may be preserved. In most cases, it is a boon when this adjustment breaks down - that is when the individual goes for help.

All persons have the need and possibility of going out from their centeredness .... to participate in other beings. This always involves risk - if he goes out too far, he loses his own centeredness - his identity. If the neurotic is so afraid of loss of his own conflicted center that he refuses to go out, and holds back in rigidity, and lives in narrowed reactions and shrunken world space, his growth and development are blocked.

THIS IS THE PATTERN IN NEUROTIC REPRESSIONS AND INHIBITIONS.

BUT, it may well be in our culture of conformity and the outer-directed man, that the most common neurotic pattern of our time takes the opposite form - the dispersing of one's self in participation and identification with others until one's own being is emptied.

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MOTIVATION

The individual is an integrated whole -- when he is hungry, it is not only his stomach that hungers -- HE needs food, not just his stomach. Many changes occur in a hungry person -- changes in his perception, memory, emotions, thinking, etc. He is hungry all over -- he is different from what he is at other times.

Hierarchy of Needs

There is an ascending hierarchy of needs; as each order is satisfied, it releases the needs of the next order.

1. Physiological needs -- food, water, oxygen, sleep, sex.
2. Safety needs -- security from threat and danger.
3. Belongingness and love needs.
4. Esteem needs -- respect, self-respect, prestige, etc.
5. Growth and self-actualization needs.

Physiological Needs: Often, though not always, can be isolated, which is not true of the other needs. They are of primary importance. When one of these is present to a high degree, all other needs are dormant and do not emerge until the ongoing need is satisfied. The organism functions entirely to satisfy this need when it is present -- it is the dominating factor in his view of the world and the future. He feels that if this need is satisfied, he will be content.

When the physiological needs are regularly gratified, they cease to exist as active determinants of behavior and remain only as potentials in that they may emerge again to dominate the organism if thwarted. A want that is satisfied is no longer a want. When these needs are relatively well gratified, the next needs that emerge are the

Safety Needs: These operate like the physiological needs, although to a lesser degree. The child does better and feels safer in an organized, somewhat structured world than in the opposite. A rejected child will cling to its rejecting parent merely to satisfy his need for safety. The average child generally prefers a safe, orderly, predictable, organized world which he can count on, and in which the unexpected, unmanageable or other dangerous things do not happen, and in which he has all-powerful parents who protect and shield him from harm.

Safety needs are not seen in the average man in our culture; they appear in the neurotic and in the economic and social underdogs.

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* Adapted from Abraham H. Maslow, *Motivation and Personality,* (Second Edition). New York: Harper and Row, 1970.

Safety needs in an adult appear in the compulsive-obsessive neurosis -- he tries frantically to stabilize and organize the world so that no unmanageable, unexpected, or unfamiliar dangers will ever appear.

Belongingness and Love Needs: If the physiological and safety needs are fairly well gratified, needs for love, affection and belongingness appear. In our society the thwarting of these needs is the most common core in cases of maladjustment. All statements relating to the previously mentioned needs apply to the love and belongingness needs.

Esteem Needs: All people in our society have a need for a stable, firmly-based, usually high evaluation of themselves, for self-esteem and for the esteem of others. Satisfaction of these needs leads to feelings of self-confidence, worth, strength, being useful and necessary. Thwarting of these needs produces feelings of inferiority, weakness, helplessness, and these feelings give rise to either basic discouragement or compensatory or neurotic trends. The most healthy form of self-esteem is based on *deserved* respect from others, rather than on external fame or unwarranted adulation.

Self-actualizing Needs: When all the foregoing needs are fairly well gratified, a new discontent and restlessness develops unless the individual is doing what he is fitted for. Man has a tendency to realize his potentials -- to become more and more what he is, everything that he is capable of becoming.

Need to Know, Understand, Explain, Satisfy Curiosity: The healthier the individual, the more eager he is to explore the unknown, the mysterious, the unorganized, the unexplained. Usually the unhealthy personality deals only with the known -- he feels safe there. The achievement of knowledge, of an insight, is usually a gratifying experience. (Children do not have to be taught to be curious -- some are taught the opposite.)

The hierarchy of needs is not rigid. Some people seem to need self-esteem more than love, although it is possible they are seeking self-esteem as a substitute for love. Some creative people need creativeness more than any other need. Some people have very low levels of aspirations, the higher goals may disappear forever, he who has experienced life at a very low level may continue to be satisfied for the rest of his life with fulfilling his primary needs. Some people who have been starved for love in their early months of their lives have lost forever the desire and ability to give and receive affection. A need doesn't have to be fully satisfied for the next need to emerge; the need need may appear when the preceeding one is partially fulfilled. Most people are satisfied with the following:

Physiological needs	85%
Safety needs	70%
Love needs	50%
Self-esteem needs	40%
Self-actualizing needs	10%

These needs are more often unconscious than conscious, the former being more important as motivating forces.

The behavior of an individual is often determined by several needs.

Thwarting of unimportant desires produces no undesirable results in the individual; thwarting of basically important needs does produce psychopathological results. A conflict or frustration is not necessarily pathogenic, but only when it threatens or thwarts the basic or the partial needs that are closely related to them.

A healthy man is primarily motivated by his needs to develop and actualize his fullest potentialities and capacities; he has no needs for esteem, love, safety, etc. -- they have been fully satisfied. The man who HAS these needs in any active, chronic sense is simply an unhealthy man just as if he lacked salt, calcium, etc.

The strong, healthy person who had all his early chronic safety, love, etc. needs fully fulfilled, no longer needs them -- he is capable of withstanding loss of love and popularity.

Some consequences of satiating a need:

1. Independence of and some disdain for the old satisfiers and goals; new dependence on newly-emerged satisfiers and goals.

2. Changes in interests, values, attention, perception, learning, etc.

3. New interests, satisfiers, and needs are higher in the scale. The easiest technique for releasing the organism from the bondage of the lower, more selfish needs is to satisfy them.

4. Gratification of any basic (not neurotic) need helps to determine character formation and tend towards improving, strengthening, and healthy development of the individual.

Differences between higher and lower needs:

1. Physiological and safety needs are deficiency or D-needs and must be optimally fulfilled by the environment in order to avoid sickness or any other feeling of ill-being. They are basic because
    a. The deprived person yearns for their gratification persistently.
    b. Their deprivation makes the person sicken and wither.
    c. Gratifying them is therapeutic, curing the deficiency-illness.
    d. Steady supplies forestall these illnesses.

2. Growth and self-actualizing needs are becoming or B-needs.

3. Higher needs came later in evolutionary development.

4. The higher the need, the longer its satisfaction can be postponed and the less imperative it is for physical survival at the moment.

5. Gratification of the higher needs leads to increased capacity for love and a truer individualism. Capacities like intelligence, love, etc., clamor to be used and cease their clamor only when used sufficiently.

6. Gratification of the higher needs produces more desirable and longer lasting results, more serenity, and happiness.

7. Pursuit and gratification of the higher needs have desirable social consequences -- higher form of selfishness (unselfish selfishness).

Healthy people have sufficiently gratified their basic needs for safety, belongingness, love, respect, etc. so that they can now satisfy their growth needs for self-actualization, integration, individualism, realizing all potentials. The individual does not know this -- his only concern is his ongoing need -- he feels that if that is fulfilled, he'll be content forever — he does not know that its gratification will open the way for his next higher need.

Impulse: Most theories of motivation regard needs, drive, motivating states as annoying, irritating, unpleasant, undesirable, something to get rid of; and motivated behavior of goal-seeking as techniques for reducing those discomforts. Freudian psychology is built upon the same attitude toward motivation adding that impulses are dangerous and to be fought. This may apply with sick people who suffer from bad experiences with their needs, gratifications, and frustrations. They find desire or impulse a nuisance or even a threat; they handle it badly, therefore try to get rid of it, deny it, avoid it (defense mechanism).

This contention is sometimes accurate for physiological needs, for safety, love, respect needs; they are problem-creators, especially for those who have had unsuccessful experiences at gratifying them and for those who cannot now depend on getting gratification.

However, one can accept and enjoy one's needs, and welcome them into consciousness if past experience with them has been rewarding and/or if present and future gratification can be counted on. This is especially true of self-actualizing impulses such as creativity. These impulses are desired, welcome, pleasurable.

Effects of gratification: Associated with the negative attitudes toward need is the concept that the primary aim of the organism is to get rid of the annoying need and thus achieve a cessation of tension, states of rest, lack of pain. This theory is very inadequate as it does not take into account the dynamic principle of growth -- as each need is fulfilled, the next higher appears, so cessation of tension may be very brief. In a man who is growth-motivated, gratification breeds increased rather than decreased motivation, heightened rather than lessened excitement; instead of coming to rest he becomes more active. Also the activity to achieve the means becomes pleasurable instead of just goal-seeking.

Clinical effects of gratification: Satisfaction of D-needs avoids illness; satisfaction of B-needs produces positive health.

Enjoyable effects of gratification: Satisfaction of D-needs brings relief; satisfaction of B-needs brings ecstasy.

Attainability of goals: D-need gratification tends to be episodic and climactic, with sometimes a sharp letting down when fulfilled. B-need gratification is a continued, upward or forward development--it is endless and can never be attained or satisfied completely.

Species goals and individual goals: D-needs are sharpened by the human species (and to some extent by other species). Self-actualization is different for each person. Species needs usually must be fairly well satisfied before real individuality can develop fully. In species needs, development is determined from without -- in individual growth needs, development is determined from within.

Dependence on and independence from the environment: Since a person's safety needs can only be satisfied by others he must be other-directed, sensitive to their approval, affection, and good will. He must adapt, adjust, change to fit the external situation since he depends on it. Therefore he is afraid of the environment -- it may fail or disappoint him. (This anxious dependence breeds hostility -- also he loses some degree of freedom.)

The self-actualizing person is far less dependent and is self-directed -- his determinants are inner -- other people may hamper him. He is less ambivalent, anxious, hostile, demanding toward others or of others; he doesn't need honors, prestige, rewards from them.

Interpersonal relations: The D-motivated person does not see others as they are, but as they must be useful to him. They are not seen as whole persons; what is not related to his needs he overlooks or perceives as boring, irritating, or threatening. Often they are interchangeable. The G-(growth) motivated person sees others as unrewarding, useless for his needs, unique, independent, individuals rather than tools. His love or admiration is based on the qualities in others, not as they are useful to him.

Ego-centering and ego-transcending: The G-M person has a strong ego and yet easily transcends it; he becomes problem-centered, self-forgetful, spontaneous. The D-M person is self-conscious, egocentric.

Learning and personality change: Learning theory is largely based on D-motivation; goal objects usually external to the organism, learning as the best way to satisfy a need. The G-M person needs little from the outside world in learning about himself, helping the steady growth of his personality becoming integrated and consistent. Change becomes much less and acquisition of habits or associations one by one and much more a total change of the total person -- new person rather than the same person with some habits added like new external possessions.

D-M and G-M perception: Since a G-M person's perception is more concrete and less selective, he more easily sees the intrinsic nature of the percept; he perceives its opposites, contradictions, incompatabilites simultaneously. A D-M person sees classes, sharp boundaries, polarites (good or bad, never both). Because the G-M person does not have to abstract need-gratifying qualities nor see the other as a tool, it is much more possible for him to be nonvaluing, nonjudging, noninterfering, noncondemning.

DEFENSE AND GROWTH

Growth takes place when the next step forward is subjectively more delightful, more satisfying than the last; not because it is good for us, we are told to do it, we will live longer, it is good for the species, it is logical, we will get external rewards. Through growth we learn what we are good at, what we really like or dislike, what our tastes, judgments and capacities are -- we discover the self.

The steps of the healthy infant are spontaneous -- exploring, manipulating, experiencing, choosing, enjoying. What interferes is the regressive power of ungratified D-needs, the attractions of safety and security, the functions of defense and protection against pain, loss, fear, and threat.

Everyone has BOTH sets of forces within him; one set clings to safety and defensiveness out of fear of taking chances, independence, freedom, separateness, risking what he already has. The other set of forces impels him forward toward wholeness and uniqueness of self.

Thus the process of growth is a never-ending series of free choices, confronting each one at every point throughout his life, in which he must choose between the delights and safety of growth, dependence and independence, regression and progession, immaturity and maturity.

If the choice is really free, not an outgrowth of a D-need, if the chooser is not too sick or frightened to choose, he will choose wisely, in a healthy and growing direction, more often than not.

Growth forward occurs in little steps, each step forward made possible by the feeling of being safe, of operating out into the unknown from a safe home port; daring because a secure retreat is available.

If the child has a choice between giving up safety and giving up growth, he will give up growth, and this choice is right for him at that time, even though it cuts him off to some degree from his self. Safety is a most basic need for children--much more necessary than independence and self-actualization. He can be helped to grow by an environment which satisfies his basic needs for safety, belongingness, love and respect, so that he feels unthreatened and spontaneous and thus dares to choose the unknown. He can also be helped by making the growth choice positively attractive and less dangerous, and by making the regressive choice less attractive and more costly.

The environment, teacher, parent, do not give the individual his creativeness, spontaneity, selfhood, etc. They permit, foster, or encourage what exists in embryo to develop, grow, become real.

NEED TO KNOW AND FEAR OF KNOWING

One of the needs involved in self-actualization is the need to know (to explore, be curious, etc.). However, there are many deterrents to the gratification of this need.

A great cause of much psychological illness is the fear of knowledge of oneself -- one's emotions, impulses, memories, capacities, potentialities, etc. This fear tends to spread so that there is a fear of knowledge in general without discriminating too sharply between the inner world of the self and the outer world. This fear is defensive -- a protection of self-esteem. We tend to be afraid of any knowledge that might cause us to feel inferior, weak, evil, shameful, etc. We protect ourselves and our ideal self-image with defenses which block unpleasant or dangerous truths.

We also tend to evade knowledge of our creativity, highest potentialities, etc. We may be fearful of the responsibility involved or the discovery that we fall short of some wish or ideal. Sometimes knowledge is felt to be too dangerous and should be left for a few special people -- if we knew, we might have to do something about what we find out. Creativity may be avoided because it may bring loneliness. Many bright women avoid knowledge and deny their need to know, because it may interfere with what they have been told is "femininity." Children may identify curiosity with trespass upon adults and adults often squelch curiosity in children, giving the latter a feeling that knowledge would make them less lovable. The bright student is often discouraged in his search for knowledge by the busy or disinterested teacher.

In spite of all these deterrents, children and adults continue to probe, explore, seek knowledge, so there must be a need. It is higher in the hierarchy than safety needs. It also may have an anxiety-reducing value -- if we feel fearful and threatened, we may get rid of the fear by exploring and finding out what the threat is. This knowledge is not nearly as satisfying as that of the anxiety-free person who can be more bold and courageous, and can explore and theorize for the sake of knowledge itself. This kind of knowledge brings varying degrees of pleasurable rewards, ranging from illumination to ecstasy.

SELF-ACTUALIZATION

In order to learn as much as possible about self-actualization, Maslow did a series of studies, selecting his subjects according to the following criteria:

> Negative criteria: No neurosis, psychopathic personality, psychosis, or strong tendencies in these directions.
>
> Positive criteria: Full use and exploitation of talents, capacities, potentialities, etc. All subjects felt safe, unanxious, accepted, loved and loving, respect-worthy and respected, and had worked out their philosophical or religious bearings.

Perfection was not sought as it was assumed it could not be found.

Full cases: 3 fairly sure and 2 highly probable contemporaries (anonymous).
2 fairly sure historical figures (Lincoln in his last years and Thomas Jefferson).
6 highly probable public and historical figures (Einstein, Eleanor Roosevelt, Jane Addams, William James, Spinoza).

Partial cases: 5 contemporaries who fell short but who could yet be used for study (anonymous).
7 historical figures in the same category (Walt Whitman, Henry Thoreau, Beethoven, F.D. Roosevelt, Freud).

Potential or Possible cases: G.W. Carver, Eugene V. Debs, Albert Schweitzer, Thomas Eakins, Fritz Kreisler, Goethe.
20 younger contemporaries who seemed to be developing toward self-actualization.

Almost all people perceive most of the time in a deficient way; they compare, judge, relate, approve, use. Self-actualization is an episode, or a spurt in which the powers of a person come together in a particularly efficient and intensely enjoyable way and in which he is more integrated, more open for experience, more idiosyncratic, more perfectly expressive or spontaneous, more fully-functioning, more creative, more humorous, more ego-transcending, more Being. Self-actualizers have these episodes more frequently, intensely, and perfectly than do average people and in their day-to-day living they are likely to be less dependent on D-need gratification.

SA frees the person from the deficiency problems of youth and the neurotic problems of life. It is not a static, unreal, perfect state in which all human problems are transcended. He deals with real guilt, sadness, loneliness, healthy selfishness, courage, responsibility, etc.

Creativity in SA People

It is different from the kind of creativity found in poets, artists, etc. (Some of these were and are definitely unhealthy, unhappy, etc.) It is not only a product but a process, an activity, an attitude, and springs much more directly from the personality than "special talent creativeness." It seems to be an ability to do anything creatively.

SA persons see the fresh, raw, concrete, as well as the generic, abstract, classification. He lives much more in the real world of nature than the verbalized world of concepts, abstractions, expectations, beliefs, and stereotypes that most people confuse with the real world -- he is open to experience.

He is more natural, able to express ideas and impulses without fear of ridicule; has an innocent freedom of perception, uninhibited spontaneity and expressiveness. This is so characteristic of children that we can conclude that all people had it originally but it became lost or buried or inhibited as they became enculturated.

He is relatively unfrightened by the unknown, the puzzling, the mysterious; may even be attracted to these qualities. He does not cling to the familiar; neglect, deny, or run away from the unknown, or pretend that it is known; does not organize or dichotomize it prematurely.

He does not need safety, definiteness, order; can be comfortably sloppy, chaotic, vague, doubtful, inaccurate, when the total situation calls for it. Doubt, uncertainty, abeyance, of decision which is for most people a torture, can be for him a pleasantly stimulating challenge.

He is less afraid of what others would say, demand, or laugh at; less need for and less hostile against them. Does not fear his own impulses, emotions, thoughts; more self-accepting and integrated.

He can superficially accept conventions, but privately be casual and detached about them. He can reject the stupidities and imperfections of the culture, and fight vigorously when he thinks it necessary. He has his own inner criteria.

He has resolved the civil war between his inner depth forces and his defense and control forces, so more of himself is available for use, enjoyment, creation. He wastes less time and energy protecting himself from himself. With his acceptance of his deeper self, it becomes more readily available for creative use.

The "normal," common sense, well-adjusted man continually and successfully rejects much of the depths of human nature because he feels it may be dangerous, but he loses much, for in these depths are his joys, ability to play, love, laugh, and his creativity. His imagination, intuitions, softness, emotionally tend to become strangulated or distorted.

We confuse primary processes with forbidden impulses (although they are not as dangerous). We do not repress or censor them; rather we forget or turn away from them as we try to adjust to a harsh reality which demands a purposeful striving rather than dreaming, playing, etc. Education, which can do little to relieve repression of instincts, may be able to help the person accept and integrate the primary processes into preconscious and conscious life through art, poetry, dancing, etc.

SA creativity seems to come from fusion of primary and secondary processes rather than from working through repressive control of forbidden impulses and wishes. It is probably that defenses arising out of fears of these forbidden impulses also push down primary processes in a kind of total undiscriminating panicky war on ALL THE DEPTHS.

SA creativity stresses the personality rather than its achievements, qualities like boldness, courage, freedom, spontaneity, integration, self-acceptance, the Being quality of the person rather than his problem-solving or product-making quality.

Imperfections of SA People

Imperfections of SA people can have silly, wasteful, or thoughtless habits; can be boring, stubborn, irritating; can have vanity, pride, partiality to their own productions, family, friends, and children; can have temper tantrums; can be ruthless (since they are very strong) and can be very cold when it is necessary or called for; out of kindness they may become involved with bores, neurotics, scoundrels, parasites, etc.

SA Growth

There seems to be evidence that the human being is so constructed that, if his D-needs are satisfied, he presses toward fuller being and toward what most people call good values -- serenity, kindness, courage, honesty, love, unselfishness, and goodness.

Characteristics of the healthy human being:

1. Clearer, more efficient perception of reality.
2. Acceptance of self, others, and nature.
3. More open to experience.
4. Increased spontaneity, expressiveness, aliveness, functioning.
5. Increased integration, wholeness, unity of the self.
6. A real self, firm identity, autonomy, uniqueness.
7. Increased objectivity, detachment, transcendence of self.
8. Problem-centered.

9. Democratic character structure.
10. Ability to love, feel, empathize, etc.
11. Independence from the environment and the culture.
12. Continued freshness of appreciation.
13. Philosophical, unhostile sense of humor.

SA Feelings

SA feelings are zest in living, happiness, serenity, joy, calmness, responsibility, confidence in own ability to handle stresses, anxieties, and problems. (Opposite feelings: self-betrayal, fixation, regression, lack of identity, anxiety, despair, boredom, inability to enjoy, introjected guilt and shame, emptiness, aimlessness, fears.)

PEAK EXPERIENCES

D-cognition -- cognition organized by deficiency needs
B-cognition -- cognition of Being

Characteristics of B-cognition in Peak Experiences

1. The experience or object tends to be seen as a whole, a complete unit, detached from relations, usefulness, expediency, purpose.
2. The percept is exclusively and fully attended to; figure is all, ground tends to disappear or merge with figure. D-cognition perceives the object as one of a class, or interrelated with and separate from its ground; it judges, evaluates, compares.
3. The world is seen as a Gestalt, not as something useful; D-cognition sees it as pertaining to and being used by himself and others.
4. The perception becomes richer with repeated exposures. D-cognizer becomes bored, attention wanders with repetition.
5. The perceiver is relatively ego-transcending, self-forgetful; can be unmotivated, impersonal, desireless; object-centered rather than ego-centered; self may disappear or fuse with the percept.
6. The experience is felt as a self-validating, self-justifying moment which carries its own intrinsic value with it -- it is not a means to an end.
7. Experiencer may become disoriented in time and space; he tends to vanish.
8. The experience is good and desirable, never felt as evil or undesirable; it needs nothing else -- it is complete, necessary, inevitable.
9. B-values appear -- wholeness, perfection, completion, justice, aliveness, richness, simplicity, beauty, goodness, uniqueness, effortlessness, playfulness, truth, honesty, reality, self-sufficiency. These overlap and fuse with each other.
10. B-cognition is passive, noninterfering, receptive rather than active; it is "choiceless or desireless awareness."

11. It creates an emotional reaction of wonder, reverence, humility, as before something great (sometimes a touch of pleasant fear of being overwhelmed); it may bring tears, laughter, or pain.
12. In some reports the whole world is perceived as a single, rich live entity; in others, one small part of the world is perceived as if it were all of the world; in both cases, the perception is of unity.
13. It is perceived with its many contradictions fused, transcended or resolved; selfish and unselfish, rational and irrational, concrete and abstract, etc.
14. At the peak, the perceiver is godlike in his complete, loving, uncondemning, compassionate and perhaps amused acceptance of the world, others, himself.
15. The percept tends strongly to be unique and nonclassified.
16. There is a complete though momentary loss of fear, anxiety, inhibition, defense and control; no delay of restraint; no fear of disintegration, death, insanity, pleasure, emotion.
17. As the essential Being of the other person or of the world is perceived, the perceiver comes closer to his own Being; this interaction seems to be both directions, for as he comes closer to his own Being he is able more easily to see the B-values in the world or in others. (As he becomes more unified, he tends to see more unity in the world, etc.)

Many of the above contrast sharply with our ordinary cognitions and reactions. We evaluate, control, judge, condemn, approve, laugh at rather than laugh with; we're concerned with usefulness, desirability; we make the world a means to our ends; thus we perceive only parts of it.

After Effects of Peak Experiences

1. May have some therapeutic effects of removing symptoms.
2. Can change the person's view of himself in a healthy direction.
3. Can change his view of the world, or of aspects of it.
4. Can change his view of and relations with other people.
5. Can release him for greater creativity, spontaneity, expressiveness, individuality.
6. He remembers the experience as a very important and desirable happening and seeks to repeat it.
7. He is more apt to feel that life is worthwhile, even if it is usually drab, painful, ungratifying, since he has become more aware that beauty, excitement, honesty, play, goodness, truth, and meaning exist.

Peak Experiences as Identity Experiences

The goals of identity, self-actualization, authenticity, seem to be a transitional goal of making the self stronger, and an end goal of obliterating the self.

1. He feels and looks more integrated, less at war and more at peace with himself, more harmoniously and efficiently organized with all his parts functioning nicely with each other.

2. He is more able to fuse with the world, going beyond and above selfhood and becoming relatively egoless.
3. He feels and appears to be at the peak of his powers -- "fully functioning"; more intelligent, perceptive, witty, strong, graceful; no longer wasting effort fighting and restraining himself; no wasted motion or energy.
4. He is not straining or struggling; appears calm and sure as if he knows exactly what he is doing, no doubts, hesitations, withdrawals.
5. He feels and looks more responsible, a prime mover, a self-determiner, sure of his worth, ability; looks trustworthy, reliable, dependable.
6. He is most free of blocks, inhibitions, cautions, fears, controls, self-criticism, reservations.
7. He is spontaneous, expressive, guileless, honest, unguarded, natural, immediate, uncontrolled, freely flowing.
8. More creative; improvises, creates out of nothing, more unexpected, novel, fresh, less premeditated. He drops his roles, becomes more truly himself, becoming more unique.
9. He is more here -- now, free of the past and future; can now listen better without expectations, preconceptions, constructs; does not compare what is here with what is not here in order to evaluate it.
10. Becomes more determined by inner laws rather than outer laws (where they differ). He grasps the nonself best by nongrasping -- letting it be itself, permitting it to live by its own laws rather than by his, just as he becomes most purely himself by refusing to let the nonself dominate his self and try to live by its laws.
11. He is nonstriving, nonheeding, unmotivated, no goals.
12. His expression tends often to become poetic, rhapsodic, etc.
13. He feels playful, happy; amused or delighted with the weakness and strength of the human being, transcending polarities.
14. He feels lucky, surprised, grateful, which often lead to an all-embracing love for everybody and everything; perceives the world as beautiful and good, is eager to repay; humility merges with pride.
15. There may be two kinds of physical reaction after peak experiences:
    a. excitement and high tension
    b. relaxation, peacefulness, stillness

Dangers of B-cognition Without D-cognition

1. Action and decision are unlikely since B-cognition is without judgments, condemnation, and evaluation. Since action and decision are necessary, D-cognition is needed to live in this world.
2. May make one less responsible, especially in helping others. The parent, teacher, therapist, must assume some responsibility in fostering growth, setting limits, disciplining, punishing, frustrating, etc.

3. Inaction and loss of responsibility lead to fatalism, loss of free will, which may be harmful to one's growth and self-actualization.
4. Inactive contemplation will likely be misunderstood by others who may suffer from it; it may be perceived as lack of interest, love, etc. and thus cause others to cease growing or regress.
5. It can lead to undiscriminating acceptance, to blurring of everyday values, loss of taste, too great tolerance. The truly SA person seems to be capable of being both therapist and policeman; usually compassionate and understanding, but also more capable of righteous indignation than the average person. Unless these are both present, effect can become flattened, reaction to people be bland, perception of and taste for real capacity, skill, superiority, and excellence be lost.
6. Others may misinterpret being perceived as "perfect." Total acceptance, love, etc. can be wonderfully growth-promoting and therapeutic, but it also can be perceived as a great demand to live up to unreal and perfectionistic expectations. The more unworthy and imperfect a person feels, the more he will misinterpret.

VALUES, GROWTH, AND HEALTH

Under free choice, mature and healthy people value not only truth, goodness, and beauty, but also the regressive, survival and/or homeostatic values of peace and quiet, sleep and rest, surrender, dependency and safety, protection from reality and relief from it, retiring into fantasy, etc. These latter are the "coasting" values as contrasted with the growth values -- he needs both. The higher needs of growth rest upon the continued gratification of the lower needs (which do not disappear, but become temporarily nonactive). The process of regression to lower needs is not always pathological, but also is absolutely necessary to the integrity of the whole organism, and required for the existence and functioning of the higher needs.

Lower needs and values are prepotent over higher needs and values most of the time for most people. Only the healthiest, most mature, most evolved persons choose higher values consistently more often (and if their life circumstances are good).

Man's higher nature, ideals, aspirations, and abilities rest not upon instinctual renunciation, but rather upon instinctual gratification.

Even the highest SA people are not exempt from the basic human predicament of being simultaneously ordinary and godlike, strong and weak, limited and unlimited, adult and child, fearful and courageous, progressing and regressing, yearning for perfection and afraid of it, being a worm and also a hero. These are not sets of dichotomies; our godlike qualities rest upon and need our animal qualities; adulthood includes the values of childhood and must build upon them. Higher values are integrated with lower values.

NEEDING LOVE AND UNNEEDING LOVE

The love need is a D-need -- if it is not available, severe pathology results; if it is available at the right time in the right quality, with the proper style, pathology is averted. The degree of the pathology depends on the state of the deficit.

D-love: deficiency-love, selfish love.
B-love: love for the Being of another person, unneeding and unselfish.

B-love is never sated, enjoyed endlessly, grows greater rather than disappears; an end rather than a means; can be vastly therapeutic; richer, higher, more valuable subjective experience than D-love; minimum of anxiety-hostility, more independent of the other, less jealous or threatened, less needful, more disinterested, more eager to help the other toward SA, more altruistic, generous, fostering; allows the other to grow, gives him a feeling of being worthy of love and respect, enhances his self-image. D-love is the opposite in most of the above; there is always some degree of anxiety-hostility.

PSYCHOPATHOLOGY

Neurosis is a deficiency disease, arising from inadequate or no gratification of needs for safety, belongingness, identification, close love relationships, respect, and prestige.

What stands in the way of growth, causes cessation and evasion of growth, fixation, regression, defensiveness? Why do so many people have no real identity, so little power to make their own decisions and choices?

1. Impulses toward self-fulfillment, though instinctive, are very weak and easily overwhelmed by habit, wrong cultural attitudes toward them, traumatic episodes, erroneous education.
2. Tendency in our culture to assume that human instincts are bad or evil, so we set up cultural institutions for controlling, inhibiting, suppressing and repressing this original nature of man.
3. In addition to the pressures foward toward health, there are also fearful-regressive pressures backward toward sickness and weakness.

Human Evil and Human Weakness

Human evil is largely, though not altogether, human weakness or ignorance -- forgivable, understandable, and also curable.

1. Self-knowledge seems to be the major path toward self-improvement, though not the only one.

2. A good therapist makes this process much easier, but it is not the only way; much that has been learned from therapy can be

applied to education, family life, and the guidance of one's own life.

3. Respecting and understanding the forces of fear, regression, defense, and safety, make it much more possible to help oneself and others to grow toward health. False optimism means disillusionment, anger, hopelessness.
4. Human weakness cannot be understood without understanding its healthy trends, and vice versa. To help others, we must realize not only that they try to actualize themselves, but that they are also reluctant or afraid or unable to do so.
5. It is very important for a man to recognize that every falling away from species-virtue, or every crime against his own nature, records itself in his unconscious and makes him despise himself. If he does something he is ashamed of, it registers to his discredit; if he does something honest or fine or good, it registers to his credit; ultimate result -- he either respects and accepts himself or he despises himself and feels contemptible, worthless, and unlovable.

BASIC ASSUMPTIONS

1. Each man has an essential inner nature which is instinctive, intrinsic, given with an appreciable hereditary determinant, and which tends strongly to persist. This inner nature includes basic needs, capacities, talents, anatomical equipment, natural inclinations. This raw material very quickly starts growing into a self as it meets the world outside and begins to have transactions within it.
2. These potentialities have a life history and a development. They are actualized, shaped, or stifled mostly by outside determinants (culture, family, environment, learning, etc.).
3. This inner core is weak, easily overcome, suppressed, or repressed. In rare cases it may even be killed off permanently by cultural expectations, fear, disapproval. It has impulse-voices, also weak at first, and the ability to hear them contributes to authentic selfhood. There are wide individual differences in the strength of these impulse-voices.
4. Each person's inner nature has some species-wide characteristics and some idiosyncratic characteristics.
5. Many aspects of this inner nature are either actively repressed because they are feared or disapproved, or they may be forgotten through neglect, disuse, etc. Therefore much of the inner nature is unconscious, not only the instincts and needs, but also the capacities, emotions, judgments, attitudes, etc.
6. Even though weak, this inner nature rarely disappears or dies--it persists underground, unconsciously. Energy must be used in its suppression or repression, causing fatigue.
7. As the inner core of self grows into adulthood, it is composed of what is there beforehand and what the person himself creates, since he continually makes choices -- thus he is his own main determinant.
8. If this essential core is frustrated, denied, or suppressed, sickness often results, immediately or later on. The main

source of illness is frustration of the following basic needs: B-values, potentials, self-expression, tendency of the person to grow in his own style at his own pace, especially in his early years.

9. This inner nature is definitely not "evil" -- it is "good" or natural. Since therapy lessens hostility, fear, greed, etc. and increases love, courage, creativeness, kindness, altruism, etc., the latter qualities seem more natural and basic than the former.
10. Evil behavior -- unwarranted hostility, cruelty, destructiveness, aggression is reactive, not basic, because uncovering therapy reduces it and changes its quality into healthy self-affirmation, forcefulness, selective hostility, self-defense, righteous indignation, etc.
11. No psychological health is possible unless the essential core is fundamentally accepted, loved, and respected by others and by the self. (The converse is not necessarily true.)
    a. acceptance and expression of the inner core or self, actualization of latent capacities and potentialities, full-functioning.
    b. minimal presence of ill health, neurosis, psychosis, or loss or diminution of the basic human and personal capacities.
12. Internalized conscience is the introjection of the disapprovals and approvals of others; its accompanying guilt is the recognition of the disapprovals. Besides the internalized conscience, a person has an intrinsic conscience, based on the unconscious and preconscious perception of his own nature, destiny, capacities. It insists that he be true to all of these -- if he doesn't he perceives in some deep way that he has done wrong to himself and he despises himself for it. Intrinsic guilt is the consequence of betrayal of one's own inner nature (a turning off the path to self-actualization) and is essentially justified self-disapproval. Out of this self-punishment may come only neuroses, but there may equally come renewed courage, increased self-respect, because of thereafter doing the right thing -- growth and improvement can come through pain and conflict.
13. The unconscious, regression, and primary process cognition may be unhealthy or dangerous or bad, but can also be good or beautiful or desirable. The roots of love, creativeness, play, humor, art, etc., are deep in the inner self or unconscious, and to recover them and enjoy them, we must be able to regress.
14. Pure spontaneity in society is not possible except in short spells, because of the world and its laws, but it IS possible in dreams, fantasies, love, imagination, sex, the first stages of creativity, free association, etc. Pure control is not permanently permissable, for then the psyche dies. Education must be directed toward cultivation of controls AND spontaneity and expression. In today's culture it is necessary to stress the latter -- we are and have been over-controlled.
15. Most of the time the normal child, if given a really free choice, will choose what is good for his growth -- he knows,

better than anyone else, what is good for him. A permissive regime does not mean that adults gratify his needs directly but make it possible for him to gratify his own needs and make his own choices -- to let him BE. In order for children to grow well, it is necessary that adults have enough trust in them and in the natural processes of growth, not to interfere too much, not to MAKE them grow, or FORCE them into predetermined designs, but rather to let and help them grow.

16. The main path to health and self-fulfillment is via basic need gratification rather than through frustration, suppression, mistrust, control, policing that goes with the belief in basic, instinctive evil in human depths. Self-denial, deliberate rejection of the demands of the organism, tend to produce a diminished, stunted, or crippled organism.
17. Complete absense of frustration is dangerous; to be strong, a person must acquire frustration-tolerance. The child whose needs for safety, love, and respect are gratified can profit from graded frustrations; if they are too much for him, they cause trauma. If they match his tolerance he learns the difference between reality and wishes, learns about his own limitations, and acquires the ability to love others as they may need it. Overprotection means that the child's needs are gratified for him by his parents; he doesn't learn to do this for himself; he remains infantile, doesn't develop. Instead of healthy learning, he learns how to use others rather than to respect them, learns that he isn't trustworthy; it is essentially condescending and insulting, making him feel worthless.
18. To make growth and self-actualization possible, it is necessary to understand that capacities, organs, etc., press to function and express themselves, to be used, and that such is satisfying, and disuse is irritating. Capacities are also needs, and enjoyable when used.
19. Cognition includes perception, learning, remembering, attending and thinking. In D-(deficiency) cognition, the world is organized into gratifiers and frustraters of our own needs, with other characteristics being ignored or slurred. B-(being) cognition is the perception of the object in its own right and its own Being, without reference to its need-gratifying or need-frustrating qualities, its value for the observer or effects upon him. With increasing selfhood, or acceptance of one's own inner nature, B-cognition becomes easier and more frequent. However, D-cognition remains for all human beings the main tool for living in the world.
20. B-love and D-love follow the same rules. No ideally good relation to another human being, especially a child, is possible without B-love, particularly in teaching. The ideal is to treat the natural world in its own right, not as if it were there only for our purposes.
21. Self-actualization rarely happens (less than 1% of the population).
22. Growth has not only rewards and pleasures but also many intrinsic pains. Each step forward is a step into the unfamiliar

and may be dangerous; also we give up something, good, familiar, satisfying; it may mean a parting, kind of death, nostalgia, fear, loneliness; often it means giving up a simpler, easier life in exchange for a more demanding, more responsible, more difficult life. Growth forward is in spite of these losses and therefore requires courage, will, choice, strength, as well as protection, permission, and encouragement from the environment, especially for the child.

23. Growth has both advantages and disadvantages. Ideal way of growing healthily is to enhance the advantages of growth and the disadvantages of not-growing (and vice versa). Defense mechanisms are prepotent over growth-tendencies, are quite necessary, and not always pathological.

24. A neurosis is not part of the inner core but rather a defense against it or an evasion of it, as well as a distorted expression of it due to fear of it. Usually it is a compromise between the effort to seek basic need gratifications in a hidden or disguised or self-defeating way, and the fear of these needs, gratifications, and motivated behaviors. Each neuroticized need or emotion or action is a *loss of capacity* to the person, something that he cannot do or dare not do except in a sly and unsatisfying way. Also he loses his will, feeling of self-control, capacity for pleasure, self-esteem, etc.

25. Absence of a system of values is psychopathological -- the human being needs a framework of values, a philosophy of life, he has a need to understand. Our present external values have been proven to be failures; we need a validated, usable, system of human values to believe in and devote ourselves to, because they are true, rather than because we are told them-- values from the inner self rather than from the environment. Much disturbance in children and adolescents is a consequence of adults -- uncertainty about their values, so they use their own immature confused values.

26. In self-actualizing people, many dichotomies become resolved, opposites become unities, work becomes play; duty becomes also pleasure; the individual fuses with nature; conscious, preconscious, and unconscious integrate; id, ego, superego merge; Freudian instincts and their defenses are less sharply set off against each other.

27. In SA people impulses are more expressed and less controlled; controls are less rigid, inflexible, anxiety-determined; superego less harsh and punishing; primary and secondary cognitive processes more equally available and valued (instead of primary processes labeled pathological); in peak-experiences, they tend to fall together. The unconscious can sometimes be healthy, regression desirable; irrationality may also be considered healthy, desirable or even necessary.

Their conative, cognitive, affective, and motor functioning are more integrated and collaborate without conflict to the same ends; what he enjoys is apt to be what is good for him; his spontaneous reactions are as capable, efficient and right as if they had been thought out in advance; sensory and motor reactions are more closely correlated, etc.

28. Abstract, verbal, and analytic thinking do not grasp the total reality, preverbal, primary process, intuitive, and esthetic types of cognition are needed for the enriched or total perception. Creativity has its roots in the nonrational; language is inadequate to describe the total reality; and abstract concept leaves out much of reality.

29 Use of the unconscious, preconscious, primary processes(without fear), impulses (without control), regression (without fear), all are the main conditions of creativity.

30. SA does not transcend all human problems; conflict, anxiety, frustration, sadness, hurt, and guilt can all be found in healthy humans. With increased maturity, the movement is from neurotic pseudo-problems to the real, unavoidable, existential problems. Guilt and intrinsic conscience are sometimes necessary. Even though one has transcended the problems of Becoming, there remain the problems of Being.

31. Mature man must learn to give up the child's wish for the exclusive, total love of his parents, while learning to love others. He must learn to gratify his own needs and wishes, rather than the needs of his parents; must learn to gratify them himself rather than depend upon them to do this for him; give up being good out of fear and in order to keep their love, and be good because HE wishes to be; discover his own conscience and give up his internalized parents as his ethical guide; replace fear with courage. All these techniques are necessary for the child, but immature and stunting in the adult.

32. "Adjustment" is NOT synonymous with psychological health -- the question is to what people, environment, or culture is the person adjusting, or how he is being used by them. True health transcends these factors and can be defined by a man's intrapsychic laws, not his ability to master the environment, to be capable, competent, etc. in relation to it. None of these is a major criterion of worth or health of a person.

33. Peak experiences are out of time and out of the world; the rest of the time, people must live in the outer world, in chronological time. The inner psychic world of emotion, wishes, fears, hopes, love, fantasy, art, etc. has its own laws, completely different from the outer world, with its laws made by others. The person who is not afraid of his inner world and enjoys it can cope with the outer world of reality more easily and enjoyably than those who are afraid of their inner worlds.

34. D-need gratifications come from the outside world -- therefore adaptation to this world is necessary; we need to learn to differentiate between the two worlds, to delay gratification, to conceal what would be dangerous, the nature of people and society, the approved and permitted outer world gratifications, and the necessary techniques to achieve them.

35. Not only does the past exist NOW in the person, but so does the future exist NOW for him, in the form of ideals, hopes, duties, plans, goals, unrealized potentials, etc.

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UNIT C : CLIENT MANAGEMENT

INDIVIDUAL COUNSELING SKILLS
UNIT C

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INTRODUCTION:
UNIT C: CLIENT MANAGEMENT

This unit is the third part of a training process which focuses on the remediation and prevention of substance dependence. Units A and B examined, 1) the phenomenon of substance use and dependence as it occurs in America, and 2) the skills necessary to work productively with the substance dependent person. In this unit, entitled "Client Management," the focus is on systemic or programmatic responses to substance dependence. This unit seeks to integrate the philosophical and practical issues which were considered earlier. The goal is to clarify which types of programmatic responses are complimentary to the therapeutic process and which types hamper the efforts of the skilled counselor. Ultimately, the counselor is either more or less effective due to the programmatic restraints and guidelines under which he/she has to work.

Module 1, "Orientation" occurs immediately following the welcome, housekeeping chores and administration of any pre-test instruments. The Orientation, although short, is important in re-establishing the tempo and atmosphere of the training community.

Module 2, "Program Diagnosis" is designed to introduce the fundamentals of client management by surfacing in a personalized way, the issues in formalized client care as they present themselves in the context of a single case.

Module 3, is entitled "The Rehabilitation Process." This concentrates on the programmatic flow through which an individual is to obtain rehabilitative assistance. The pros and cons of various program procedures are discussed.

Module 4, "Intake and Assessment" examines the data needs of a program at the point of intake. A case study assignment affords practice to all participants in identifying significant intake data.

Module 5, "Treatment Planning" is a didactic session and laboratory experience in treatment planning, including issues such as goal selection, managing clients by objectives and team approaches to treatment.

Module 6, is "Confidentiality and Ethical Considerations," wherein counselor conduct is discussed. Both Federal Regulations and moral and ethical issues are considered.

Module 7, "Community Organization," is a review of skills and strategies for developing community (any group of persons such as a village, county, congregation, program staff or union---persons who share some sommon bond) rapport and cooperation in problem-solving activities. The trend toward developmental activities is explored and negotiation skills are emphasized. Resource identification skills are introduced focusing on the need of the counselor to be conversant with alternate and supplemental client-oriented services. A schematic for developing this knowledge is presented. Participants will develop an individual action-plan-for-change to be implemented in their own programs.

Module 8, "Closure," reviews the training design and the purposes for various training activities within the design context. The training experience is brought into perspective and brought to a conclusion in this module.

TIME REQUIRED: 3 Days

TRAINING GOALS

To place client management and program practices into an operational perspective so that the counselor will be able to:

- Distinguish between therapeutic and non-therapeutic processes
- Identify areas of policy and practice which reduce the effectiveness of programs
- Construct more effective therapeutic environments
- Develop appropriate therapeutic goals for/with clients
- Understand methods for implementing program and community change
- Develop an action-plan-for change in their back-home substance abuse facility

TRAINING OBJECTIVES-COMPONENT C

I. Trainees will increase knowledge on addictions and counseling by 30 percent as indicated on a pre-post test.

  A. Given a list of six negotiating elements, trainees will be able to define four of the elements. (Ref: handout and presentation)

  B. Given the seven principles of behaviorial change, the trainees will be able to cite two conflicts between program process and the proper principles.

  C. Concerning clients in the trainees own program, the trainee will identify an increased number of decision points and an increased number of program personnel involved in the treatment decision-making process after training than before training.

  D. The trainees will be able to list the six steps of community development. (Ref: presentation)

II. Trainees will express a significant positive change (.05 level of statistical significance) in the attitudes below.

  A. Given the statement, "I am willing to discuss procedural problems with my supervisor, or program director even though there may be a disagreement about the problem," the trainee will express increased willingness to discuss program process.

  B. Given the statement, "A program ought not to cater to differences in client treatment needs," the trainee will express an increased need to deal with client differences.

III. Trainees will meet the following training objectives upon completion of training session (Component C).

  A. Given a case study, the trainees will experience as a group the processes of assessing data, writing a treatment plan, and selecting modes of treatment.

  B. The trainees will be able to develop an action plan for their program or community.

UNIT C:

PRETEST AND POSTTEST

PRETEST

NAME ____________________

DATE ____________________

BSACTP -- COMPONENT C

1. Opposite the appropriate principle, give two examples of conflicts between program process and the principles of behavioral change.

    1. Establish relationship (explicit, empathetic).

    2. Focus on the here-and-now pain.

    3. Opening feedback channels.

    4. Formulation of the problems.

    5. Explore options/aternatives.

    6. Risk/integration.

    7. Action plan.

2. How many decision points are there concerning each client in your program?

3. How many different staff make decisions concerning clients in your program?

4. I am willing to discuss procedural problems with my supervisior or program director even though there may be disagreement about the problem.

agree ├──┼──┼──┼──┼──┼──┼──┼──┤ disagree

5. A program ought not to cater to differences in client treatment needs.

agree ├──┼──┼──┼──┼──┼──┼──┼──┤ disagree

POSTTEST

NAME ______________________

DATE ______________________

BSACTP -- COMPONENT C

1. Opposite the appropriate principle, give two examples of conflicts between program process and the principles of behavioral change.

   1. Establish relationship (explicit, empathetic).

   2. Focus on the here-and-now pain.

   3. Opening feedback channels.

   4. Formulation of the problems.

   5. Explore options/aternatives.

   6. Risk/integration.

   7. Action plan.

2. How many decision points are there concerning each client in your program?

3. How many different staff make decisions concerning clients in your program?

4. I am willing to discuss procedural problems with my supervisior or program director even though there may be disagreement about the problem.

agree ├──┼──┼──┼──┼──┼──┼──┼──┤ disagree

5. A program ought not to cater to differences in client treatment needs.

agree ├──┼──┼──┼──┼──┼──┼──┼──┤ disagree

6. List four of the six elements of negotiating.

   1.

   2.

   3.

   4.

7. List six steps in community development.

   1.

   2.

   3.

   4.

   5.

   6.

MODULE 1: ORIENTATION

MODULE 1: ORIENTATION

Focus, Objectives & Resources

FOCUS

The orientation to Unit C is an overview which puts it into the context of the entire course. Unit C is placed in perspective and the expectations of which the training staff has of the participants is made clear.

Unit C is conducted in a seminar format, with the training staff giving structure but the bulk of the learning coming from interaction between the participants and the staff, and from the participants with other participants.

This final unit seeks to integrate the perspective built in Unit A and the counselor skills developed in Unit B into the program context. Knowing what to do with a client and being able to accomplish it depends to a large extent upon the system in which both the client and counselor are working. Systems or programs can either aid the therapeutic process or significantly hinder it depending upon its organization and function. Exploring these issues will be the major thrust of this unit.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- State the major emphasis of Unit C.
- Explain the role of Unit C in the overall course content and flow.

RESOURCES REQUIRED

The learning activities in this module will require:

- A trainer
- A large room
- A copy of the schedule for each participant
- A flip chart and felt tip pens
- A copy of this Training Manual as a resource
- Small meeting rooms for four small groups

- A copy of the pre-test for each participant
- Pencil and paper for each participant
- Masking tape

MODULE 1: ORIENTATION

Learning Activity Schedule

Activity 1
(30 Minutes)

Pre-Test
Briefly explain the purpose of the pre-test instrument for each participant as suggested in this manual for Units A and B.

RESOURCES REQUIRED

- A lead trainer or cycle manager
- A copy of the pre-test for each participant
- Pencils

Activity 2
(30 Minutes)

Trainee Welcome and Orientation
As in previous components, welcome the participants to the training facility in order to help them feel at home with the shcedule for this Unit.

Follow this with a short overview of the training focus for Unit C in terms of both content and process, noting how Unit C flows from A and B.

RESOURCES REQUIRED

- Lead trainer or cycle manager
- One reference copy of this manual
- A large room with flexible seating
- A copy of the daily training schedule for each participant

MODULE 1: ORIENTATION

Trainer Guidelines

Activity 1 (30 Minutes)	Make a brief presentation designed to set participants at ease about the pre-test.

Activity 2
(30 Minutes)

In order to set the stage for the learning during this unit and to develop a good learning atmosphere the trainer must make a high-energy presentation which will allow the participants to get excited about upcoming activities. This module should be undertaken after welcomes and housekeeping duties are concluded, and after the administration and any pre-training evaluation instruments.

The trainer should include an explication of the design and how Unit C flows naturally from Units A and B. This unit should be introduced in such a way that the participants see it as the culmination and final integrationg of the training activities. The result of this module should be affective, i.e., a heightened investment in the upcoming process.

Care should be taken to create a proper learning atmosphere and the natural levity and comraderie likely to surface on the occasion should be channeled into productive areas.

Units A and B focused on what the client needed and how an individual counselor assists a client in meeting those needs. This unit focuses on the system which delivers the services and considers ways in which the counselor is often aided or frustrated by that system in his/her attempt to deliver those services. As an analogy we might recall that while the People's Republic of China had atomic capability a dozen years ago, they were incapable of using an atomic bomb as an offensive weapon because they had no way of getting the bomb from mainland China to the target. In other words, they had both the knowledge and skill necessary to build a bomb, but no delivery system to implement their atomic capability. Thus, they became a paper tiger. The goal of this unit is to provide an understanding of the delivery system necessary to assist clients in their counseling programs and thereby reduce the number of "Paper Tiger Programs" which, though staffed with skilled counselors, are not able to deliver a satisfactory treatment regimen.

MODULE 2: PROGRAM DIAGNOSIS

MODULE 2: PROGRAM DIAGNOSIS

Focus, Objectives & Resources

FOCUS This diagnostic experience is designed for each participant to construct a flow chart of client movement through his/her program. After constructing this chart, each participant is asked to identify each point at which a decision is made concerning the client. These decision points become the basis of discussion throughout this module and the issues raised here are referred to during the duration of the training.

LEARNING OBJECTIVES At the conclusion of this module each participant will be able to:

- Identify three points in his/her own program where the program staff makes a decision about the clients treatment program.
- Explain the criteria by which client oriented decisions are made.
- Identify the decision-makers in his/her programs.

RESOURCES REQUIRED The activities in this module will require:

- A trainer
- A large room
- A facilitator for each six-eight people
- A small group room for each facilitator
- Pencils
- Newsprint and felt markers for each participant
- Masking tape for each six-eight people

MODULE 2: PROGRAM DIAGNOSIS

Learning Activities Schedule

Activity 1
(2½ Hours)

Diagnosis of Participant's Program

The training community is divided into three to four small groups taking care to mix those persons who may come from the same or similar programs. In the small group, the facilitator instructs each person to complete and finalize the homework assignment for this Unit. The participant should note in writing the actual steps (planned and unplanned) through which a typical client might move through his program facility. The participants are asked to transfer this information to newprint in the form of a client-movement-flow-chart, and then to star in red the points at which decisions are (formally or informally) made about the client's treatment.

When all have completed their flow-charts, each client shares his with the group. The facilitator will assist each presenter probe his program in more detail by asking him/her to identify (1) what the indicated decision is (2) who in fact actually makes(d) the decision (3) what are the criteria used for making the decision. The facilitator should press each participant for specificity about what actually occurs (not what idealistically ought to occur) in his/her program. A certain dissonance about one's program and one's participation and knowledge of his/her program is desireable.

RESOURCES
REQUIRED

- A facilitator for each six - eight people
- A small group room for each facilitator
- Pencils
- Newsprint and felt markers for each participant
- Masking tape for each six - eight people
- The homework assignment for each participant

MODULE 2: PROGRAM DIAGNOSIS

Trainer Guidelines

Activity 1
2 1/2 Hours

The trainer should make a cogent, short presentation of the purpose of this module. Emphasis should be placed on the identification of decision points and of the criteria used to make the decisions. After moving into small groups, each person should work alone, even if there are people present who work for the same program. Each participant should struggle through his/her own perception of the program. Not knowing certain important data significant, and the implications for this can be explored throughout the session.

Small groups of about six are preferable. Larger groups will take much longer to complete the activity. Each participant should report briefly on the program, spending the majority of the time on decisions, decision-makers and criteria used for making the decisions.

Some areas of interest for discussion may be the appropriateness of the decision-maker (does he/she have access to the data, etc?), the criteria by which decisions are made, the extent to which clients are consulted in the decision-making progress and the data which the individual counselor does not know about the program.

This activity should terminate in the small groups, with the facilitator taking responsibility for each individual having the opportunity to deal with feedback, discussion and dissonance which may have been raised.

MODULE 3: THE REHABILITATION PROCESS

MODULE 3: THE REHABILITATION PROCESS

Focus, Objectives & Resources

FOCUS

The topic of rehabilitation as a process is introduced and examined. Many errors often seen in rehabilitation programs are examined, as well as an overview of practices which seem to be yielding positive results. Participants have the opportunity to fully participate in the discussion in a give-and-take setting.

LEARNING OBJECTIVES

At the conclusion of Module 3, each participant will be able to:

- Identify three errors commonly made in rehabilitation programs.
- Explain the concepts of "middling" and "picking-off" of program staff and explain two ways to avoid these problems.
- Identify at least two client management problems which should be considered in staff meetings.
- Explain the need for careful organization and monitoring of the intake and assignment processes.

RESOURCES REQUIRED

The activities in this module will require:

- A trainer
- A large room
- A flip chart and felt tip pens
- A facilitator for each eight participants
- A small room for each facilitator
- A copy of the resource paper for each participant

MODULE 3: THE REHABILITATION PROCESS

Learning Activity Schedule

Activity 1
1-1¼ Hours

Trainer Presentation

The trainer will make a presentation on the rehabilitation process, highlighting the historical foibles in many systems and giving a rationale for change. The presentation will be on a seminar basis, with the participants sharing in the input and providing discussion and examples for the training community to consider.

RESOURCES REQUIRED

- A trainer
- A large room
- A flip chart and felt tip pens
- A copy of the resource paper for each participant

Activity 2
1-1¼ Hours

Small Group discussion

In small groups the participants will discuss the activities in Unit C to this point. During this discussion, participants will have the opportunity to identify particularly salient ideas and share with others the particular relevance of these ideas.

RESOURCES REQUIRED

- A facilitator for each eight participants
- A small group room for each facilitator

MODULE 3: THE REHABILITATION PROCESS

Trainer Guidelines

Activity 1
(1 - 1 1/2 Hours)

This presentation should be hard hitting and should stress the connection between the process of behavior change outlined in Unit B and the program procedures and red tape which often negate the efforts of a good counselor. Through the use of hyperbole and comedy, the trainer can talk about negative practices which may be currently in use by the participants without engendering ill-will or precipitating confrontation. The group needs to be "massaged" in such a way that the foibles of their programs can be discussed in such a way that they can consider the data objectively.

Personal examples from the trainer's own experience, including personal mistakes in the past, should be used to illustrate the kinds of errors which disrupt the work of clients and counselors. Input from the community should be solicited, and personal examples offered by participants should receive particular attention.

The problems which arise in non-communicative systems should be noted. The problems of assignment of clients to particular modalities and counselors without discussion and/or criteria should receive special attention. It should be noted how treatment staffs get middled and picked-off by clever clients when the staff does not keep in close contact. The problems of mixed messages from a treatment staff is an important one and its implications should be explored.

Activity 2
(1 Hour)

In the small groups the participants should make the connections between the program diagnosis done earlier in the day and the presentation in the rehabilitation process. Encourage participants to make specific identifications between the similarities in the presentations and some of the possible or actual problems in their programs. The participants should EIAG the activities in Unit C to this point. (See Unit A, module 2 for a discussion of the EIAG process.)

THE REHABILITATION PROCESS

by

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Prepared

by

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THE REHABILITATION PROCESS

In Part A of this course we described rehabilitation as the process of helping a client learn, through his or her own practice and experience, the skills necessary to respond with nondependent behavior in situations where he or she formerly responded with dependent behavior (substance abuse). In other words, we are asking programs to assist a client in changing his or her behavior. In Part B of this course we laid out seven steps necessary for behavior change to occur. We noted that problems which arise in the process of behavior change can often be traced to omission or inadequate development of one of the seven steps. Since we are asking rehabilitation programs to be agents of behavior change, looking at our programs in terms of the seven steps for behavior change can help us identify areas where our programs can improve their effectiveness.

Many programs experience difficulty because they fail to establish an explicit, empathetic relationship with their clients (Step #1). A program's ability to be an effective agent for behavior change depends on the client's perception of the program. This perception can make or break a counseling relationship so it is important to become aware of a client's perceptions, attitudes and feelings about coming to the program. By really putting ourselves in the client's shoes we can begin to build an empathetic relationship.

A client's perception of your program may have been formed long before he enters your door. His perceptions are influenced by the community's awareness and perception of the program and by the process he has gone through in getting to your program. Obviously, a client who has been sent to your program as a term of his probation, or forced into your program by family members will be carrying attitudes and feelings that each staff member must be sensitive to. A more subtle influence on the client's attitude toward the program is the community's perception of the program; however, a staff member can influence the community's perceptions of the program by working with the community to build an explicit relationship with the residents. The amount of community education you do, the publicity the program receives, and the program's community involvement all influence the community's (and therefore the client's) awareness of and feelings toward the program. I am sure we would all feel more comfortable coming to (or being sent to) a program that had made an effort to inform the community about its functions through an active campaign of outreach, community involvement, and community education, than to a program that had made no effort to explain itself to the community with a staff that stayed in the office waiting for clients to come to them. Obviously, the involved program can do much to ease the fear, suspicion, and bewilderment about coming to (or being sent to) the program by educating the community about its activities and by personalizing the program through direct staff contacts in the community.

Once the client arrives at the program we are at a crucial point in the process of building a relationship. We can verbalize concern for the client, but if he is told to have a seat while the secretary types and the counselors chat we won't communicate concern. Similarly, giving the client a form to fill out or an appointment for next week can only damage the relationship. It takes a lot of courage to come to a program and ask for help and it takes a lot of pain to drive a person to a counseling program. Future appointments and intake forms do nothing to deal with that pain and they often frustrate a client to the point of changing his mind about seeking counseling. Everyone working in a program should be trained in crisis intervention and interview techniques. The client came for help now and should be seen now. It may be our only opportunity.

This brings us to the second principle of behavior change, focusing on the pain in the here and now. We must make every effort to treat the client when he first contacts the program (even over the phone). During this initial contact we must make every effort to keep his focus on the pain or discomfort that brought him to the program or got him into trouble. Many of the procedures and red tape required by programs shift the client's focus away from the here and now. Intake interviews, for example, often ask questions about past arrests, past substance involvement, and past treatment experience, or demographic data that has nothing to do with why the client is in the program right now. Moreover, focusing on such an intake procedure may tell the client that we care more about getting our paper work done than we do about him and his problem. If we establish an empathetic relationship and help the client with his problem, he'll usually stick around to give us the demographics.

Step three in the process of behavior change involves opening feedback channels in both directions. It is our responsibility to make certain this component of the change process is present on both a counselor/client and a programmatic level. We must insure open honest feedback to and from clients, other staff members, and the community we are serving. A program that does not give feedback to clients, staff members, and the community isn't living up to its responsibility as an agent of change. A program that doesn't solicit feedback from clients, staff members, and the community it serves becomes a rigid non-communicative system and is heading for trouble. For example, a program that doesn't have a method of receiving feedback from clients will never learn how the program is perceived by clients or how its services could be improved to better serve its clients. A program that has no procedure for giving (community development and education) or receiving (periodic needs assessments, open board meetings) feedback from the community it serves cannot hope to impact (change) the community and is in danger of becoming obsolete as the community changes and the program stays the same. A program that doesn't set up procedures (regular staff meetings, joint treatment planning, regular case review) that promote open communication and honest feedback among all staff members, faces a myriad of potential problems including sabotage of the process of behavior change by clever clients or petty staff disputes. For example, unless staff members meet regularly to discuss client treatment plans, counselors lose creative input from other staff members on their observations of the client and their ideas on how the client can best be served. Moreover, it is important for each staff member to be aware of each client's needs and treatment goals in case the client needs help when his primary therapist is unavailable. In residential programs, clients will often undermine staff members and sabotage program efforts by asking several staff members about a program policy or asking several staff members for a favor. Unless the staff is familiar with the client's treatment plan and has a procedure for dealing with such requests, the client can "pick off" certain staff members and expose a noncommunicative program. A program must establish and commit to writing a set of policies and procedures aimed at opening feedback channels to and from clients, community, and staff.

Step four in the process of behavior change is formulating the problem. Suffice it to say that many substance abuse programs don't really help a client identify the actual problem. Instead, programs often identify every client's problem as a drug problem or an alcohol problem. This is the "one way" approach mentioned in Part A of this course. This approach meets the needs of the program rather than the needs of the client. Unless a program is flexible enough to look beyond the symptom (substance abuse) and help the client discover his real problem the process of behavior change is short-circuited.

Similarly, the program that doesn't help a client discover his real problem usually doesn't help the client explore optional behaviors (Step #5). The program that is quick to identify the client's problem (drugs, alcohol) often has a standard solution (one-to-one counseling, abstinence). The program that is really interested in helping clients find new ways of behaving will encourage clients to explore all possible options and will individualize each client's treatment plan. This doesn't mean that the program must provide every alternative itself. Limiting clients to those alternatives that are available through your program restricts optional behavior. Offering two or three ways isn't much more flexible than offering "one way." Almost any community offers a wealth of alternative activities and the effective program learns as much as possible about each of these alternatives so that the resources of the community are at the program's disposal and can be mobilized to assist in the process of behavior change. Moreover, the effective program encourages each client to explore and select options of his own creation as the client takes greater responsibility for his own behavior change.

Once the client has selected the optional behavior he feels is most appropriate the program must help the client integrate and risk the new behavior (Step #6). The program must provide a nonthreatening learning atmosphere where the client has the opportunity to practice the new behavior so that he will be prepared to risk the new behavior outside the program. Programs that help the client identify the problem, choose the new behavior, and then send him on his way are setting him up for failure. The client will have no safe environment to practice his new behavior unless the program encourages the client to risk the new behavior in the program. If he has trouble risking the new behavior around his counselor, imagine how difficult it will be to try around his family.

Even when the client has had the opportunity to risk the new behavior in a nonthreatening environment, failure is still a possibility. The process of behavior change is not complete until the client has explored this possibility and the other reactions his new behavior may cause. Programs should explore the contingencies (Step #7) with the client and build follow-up procedures into the program that take these contingencies into account.

The rehabilitation process is a process of helping a client substitute nondependent behavior for his substance-dependent behavior. Successful execution of the process requires that all the steps for accomplishing behavior change be present and adequately developed on both the client-counselor and the programmatic level. It is the responsibility of each staff member to make certain that the program lives up to its responsibility to be an agent of change by a careful consideration of the seven steps on the programmatic level.

MODULE 4: INTAKE AND ASSESSMENT

MODULE 4: INTAKE AND ASSESSMENT
(2½ Hours)

Focus, Objectives & Resources

FOCUS

This module focuses on the screening process by which clients are admitted to a program and assigned to a particular counselor and/or method of treatment. The types of information necessary for an assessment of the client to be made are isolated and discussed.

LEARNING OBJECTIVES

At the conclusion of this module each participant will be able to:

- o Identify three items of importance for the intake process.
- o Demonstrate an operational understanding of the intake process by identifying salient intake information contained in a case study.
- o Name three types of unnecessary information often gathered during the intake process.

RESOURCES REQUIRED

- o A trainer
- o A large room
- o A case study for each participant
- o A facilitator for each six-eight participants
- o A small group room for each facilitator
- o A flip chart on newsprint and felt tip pens for each facilitator
- o Masking tape
- o A copy of the resource paper for each participant

MODULE 4: INTAKE AND ASSESSMENT

Learning Activity Schedule

Trainer Presentation

Activity 1
1 Hour

The trainer will make a presentation and lead a group discussion on the intake process. This discussion will encompass the purpose of the intake process and will identify the types of data a counselor needs from the intake process in order to make the proper assessment concerning the initial stages of the client's treatment program.

RESOURCES
REQUIRED

- A trainer
- A large room
- A flip chart and felt tip pens
- A copy of the resource paper for each participant

Activity 2
1 Hour
(More if
required)

Case Study - Data Gathering

In this activity, each participant will be assigned to a small group of six-eight persons with a facilitator and will receive a copy of the study with the assignment to identify the significant data. The case study is viewed as the information gleaned from an intake process and the participants identify the information which is significant from the standpoint of intake and assessment procedures.

Each participant is asked to take such individual time as necessary (probably an hour on the average) to thoroughly study the case material and to identify by underlining, making notes, etc. the data which is significant for treatment planning. Emphasis is made, that at this point, no consideration is to be given the treatment plan or treatment process -- just the identification of significant data.

RESOURCES
REQUIRED

- A facilitator for each small group
- A large room
- A copy of the case study for each participant

MODULE 4: INTAKE AND ASSESSMENT

Trainer Guidelines

Activity 1
(1 Hour)

The trainer should make a presentation on the criteria for intake assessment of data based on the concepts of habilitation and the seven principles presented in Units A and B. In a discussion format, the trainer should elicit from the group a list of data which is important to gather during the intake process. Data is important when it provides a basis for making decisions about the client's treatment regimen. Such decisions include, but are not limited to, the client's acceptability to the program, assignment to a type of treatment or modality and assignment to a specific counselor.

A good method for this process is to allow the participants to "brainstorm" ideas without editing their responses, and they asking them why each idea is important. Each element of information should contribute or lead to some decision about the client's treatment or it does not help in the assessment. Any information which doesn't meet this criterion should not be on the list. In this way, the list can be reduced to the essential information points which are necessary to gather from the client at the time of intake in order to make the assessments necessary to his/her treatment program.

Activity 2
(1 Hour,
more if
required)

The case study (the one at the end of this module, may be used, or another suitable one may be substituted) is begun in small groups of six-eight persons. It is to be done individually by each participant. It should be emphasized that the point of the experience is to identify the significant data, not assess or analyze it. There need be no treatment recommendation arise from this activity.

After ascertaining that the instruction is clear and that each member of their small group is able to work on the assignment, the facilitator may leave the participants to complete it on their own. The facilitator should mention that the completed work will be the basis for the next morning's activity.

CRITERIA FOR SELECTING
CLIENT INTAKE DATA

by

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CRITERIA FOR SELECTING CLIENT INTAKE DATA

When a client first contacts a helping program, most of us would agree that we in the program should relate to him responsibly. This means being responsible to him and for him as is appropriate.

In the Seven Principles of Building a Client-Counselor Relationship for Behavioral Change, we list (1) establishing empathy with the client and (2) establishing a clear, explicit and shared understanding of why the counselor and client are together and what is expected of each --- as the initial matters of counselor concern.

With regard to establishing empathy, it is not difficult to see how the process of gathering intake data can be, and frequently is, anything but an empathy building process. For reasons not altogether clear, intake interviewers (counselors) put a client through a most unempathic data gathering experience usually because the "program requires that this form be filled out." Suffice it to say that the intake process, in terms of human dynamics, needs to be looked at with a critical eye and with an openness to the possibility of changing it. Intake is all too often a first contact a client has with the therapeutic process, and in terms of process, should not work against this therapy.

On the other hand, gathering intake data can be and should be an important step in establishing a clear, explicit understanding of why the client and the program (counselor) are coming together. The intake interviewer has the responsibility for managing what data is solicited and what data is not solicited. To this end, this paper is offered to provide some guidelines for the intake interviewer.

Counseling in the substance abuse field deals with changing behavior. Different behavior is the sought end result. Depression, poor domestic relations, unemployment, etc., all may be desireable to change --- but it is the client's own personal behavior that we deal with --- not the situations themselves.

If, therefore, we will work with the client to help him change behavior, we have to know (and he does, too) how he is behaving now. What is he doing now that he wants to do differently? Unfortunately, clients frequently don't want to deal with changing their own behavior or even suspect that their own behavior creates the painful "situations" in which they find themselves. They would rather focus on changing others or changing situations. Nevertheless, our job is helping a client change his behavior.

This has a direct relation to gathering data. We want to gather data about how a client is functioning (behaving) now in the significant areas of life. We want to know what he is doing in the areas of his inner-self, his relations with others, and his organization of his life in that little part of the world in which he lives.

I want to bring up at this point another concept with which we dealt --- the concept of the "Whole Person." If we are true to what we have said, we are interested not simply or primarily in our client's substance abuse but what he is doing for himself physically, mentally and spiritually. My point is, then, that our intake questions (management) should reflect this total concern. The questions asked a client at intake all too often reflect a very narrow concern, such as his substance use.

Okay, we have said we (1) want to discover how a client is behaving (functioning) now in the significant areas of life and (2) want to discover how a client is behaving now in the totality of his life --- all parts of him.

What are significant areas? Let's list all those we can in which any whole person might be concerned: It is improbable, perhaps impossible, that all the important data in these areas can be obtained during an intake. Yet it is ultimately important to learn about these areas, and where data does fall out in intakes, it is helpful to assign it to its appropriate area of concern.

I. Physical

1. Basic demographics: name, age, address, phone, etc. (just enough!)
2. Health now, including history as it affects the now.
3. Physical habits now including sleep, work, relaxation, substance abuse, etc.

II. Interpersonal

1. Family, parents, children including any history that has relevance now.
2. Significant human relations outside of family.

III. Education/Vocational Skills

1. What can he do? What does he know?

2. What is his educational and vocational history that has relevance now?

IV. The Self

1. Does he like himself? How does he describe his self - concept? What are his social imprints, the tapes, the messages he responds to now?

2. What does he do for his emotional and spiritual well-being now?

3. What areas listed above (Physical, Interpersonal, Educational/Vocational) is he dissatisfied with? okay with?

4. What are his intrapersonal skills? self-discipline? personal responsibility? ability to make personal decisions and act on them?

5. What is his presenting problem as he sees it now? What is he doing?

V. Organizing Capacity

1. What does he do to organize his activities? How does he make judgments? assessments? about the situations in which he lives?

2. Does he know how "the system" works? how to get a job? plan and save for future needs? etc.

3. Social-legal history - what have been his contacts with the law, etc.?

One important aspect of gathering data about a client is to distinguish very clearly between (1) fact --- "what happened" and (2) opinion --- the assessment or interpretation of the facts. With regard to (2) opinion, it is also important to distinguish between "whose opinion" --- the interviewer's or the client's. What's terribly important is for the intake interviewer *not* to make interpretations about facts or assumptions of which he himself is unaware. Know that your assumption is just that --- an assumption, not a fact.

Nevertheless, it is the job of the intake interviewer to assess the significance of the "facts," the information and data presented to him by the client. I shall suggest two criteria to use in this respect:

1. Look at the data given about the significant areas of

life (Physical, Interpersonal, Evaluation/Vocational Skills and Organizing Capacity) from the point of view of Habilitation Skills (sometimes referred to as Survival Skills!). Remember, Habilitation Skills are three: (1) Intrapersonal (decision-making, personal responsibility, personal goals, personal assessment) (2) Interpersonal (communication, listening, capacity for empathy, ability to give and receive love) (3) Organizational (capacity for judging and assessing situations in which he lives, planning and forecasting).

Look, then, at the data you receive about your client --- himself, his family, his job, his education, his health, his substance use, etc., and ask yourself: "Which of the Habilitation Skills does this data speak to?" Does what he tells you point toward Intrapersonal, Interpersonal or Organizational Skills? Does his drinking, his family, social, legal and vocational history point to poor interpersonal skills? organizational skills? When, through your assessment of the data, your suspicion that one of his survival skills is limited, you may wish to go back over the significant data areas again looking at them with this particular habilitation skill in mind.

2. Cluster all the data you can assemble in terms of the particular survival skill. By clustering drinking behavior data, for example, with other data (marital, physical, legal, etc.), it may be quite evident to you that he needs to be trained in, say, Intrapersonal Skills. You then will have some clue as to the appropriate form of treatment plan you will recommend, which is the main reason for intake data gathering in the first place.

To say what has been said again by way of summary:

1. Evaluate the intake questions and procedure in terms of empathic relationship building.

2. Look at intake data gathering in terms of establishing explicitly "why you and the client are together --- what you expect from each other."

3. Substance abuse counseling has the goal of client behavior change. Therefore, the data gathered about a client should be behavioral.

4. We believe in the "Whole Person" concept and the data gathered should be related to all significant areas of a client's life.

5. Distinguish between "data" and "opinion." What are the facts?

6. Determine whose opinion. Yours? Your client's? His wife's?

7. Give significance to data collected in terms of the client's habilitation skills.

8. Cluster, assemble the data under one or more of the three habilitation (survival) skills.

9. Having determined the particular habilitation skill that is deficient, your treatment plan may be designed appropriately.

CASE HISTORY

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CASE HISTORY

INFORMATION FROM PRESENTENCE INVESTIGATION

On 4-13-72, client was stopped at 1:30 a.m. after being observed to be driving in a reckless manner. He was subsequently given a BAC test and scored .24%. Client stated that he had stopped for a few drinks after working an extra long day and was going to stop at a restaurant for coffee and a sandwich before going home. He was not sure why he was stopped by the police.

Client was born in Cleveland 31 years ago and was brought to Indianapolis when only a few months of age. His parents were divorced when he was six and he saw very little of his father from then on. His father remarried and fostered a home in Michigan but the client and his brother were raised by his mother and maternal aunt.

Client quit high school and joined the Navy at age eighteen. He was in the Navy from 1958 to 1962 and received an honorable discharge. He received his G.E.D. certificate while in the Navy and when discharged he attended Los Angeles City College for two years.

Client married present wife in 1968 in Walton, Indiana. Neither had been married before. They have an infant son.

Client currently works at the Carpet Center as a salesman and has been with them since summer, 1972. He earns about $250.00 gross weekly but works every day of the week. He maintains that he has several sizable debts and that his earnings dropped considerably last year. Because of his earnings in the present job, he expects his financial situation to improve.

He is a sports enthusiast and enjoys local college and professional basketball. He played football in college and high school and follows this sport rather carefully. He states that his son gives him much pleasure and motive for staying around home. He has always enjoyed good health.

He is Protestant but does not attend church services.

Regarding his arrest, he realized police have a duty as well as he as a citizen, but since settling down when he got married, he expected no incidents such as this to happen. He seems to be serious and sincere in his attitude toward his wife and family, and proud that he has a job that enables him to care for them accordingly.

At the time of his arrest, his BAC test revealed .24% and later when given the Michigan Highway Safety Test, he scored 44. Although he has had a couple of scrapes with the law, he had only one prior OMVUIL charge and that was in California seven years ago.

Client was put on probation and attended DWI school. On the Johns Hopkins Test and "Who Has A Problem?" questionnaire, he answered affirmatively to only two questions, revealing that drinking makes him irritable and that he is embarrassed by things he says and does when drunk. In DWI school, he indicated interest in receiving further counseling and was scheduled for an appointment with the ASAP Health Countermeasures counselor, on 12/14/72.

INFORMATION RECEIVED FROM FIRST INTERVIEW

Client arrived promptly. He was well-dressed and well-mannered. He gives the appearance of a high school football hero. He wants us to determine if he has a drinking problem. During the discussion of the drinking habits, etc., he finally admitted he is desirous of assistance with a 26-year-old wife who has become quite obese and does not want to work, but is becoming quite uneasy with the "four walls" at home. There is an eleven-month-old baby that keeps him from leaving. He is completely "turned off" by her sexually, primarily due to the weight. He indicates that he is both mentally and physically exhausted. He feels he should never had married, but felt family pressure to do so when he was in some legal trouble and it was believed that being married might prevent him from going to prison. (He was found guilty four years ago of intent to commit a felony-burglary, but placed on probation.)

Client does admit to drinking and indicates he was really "loaded" the night he was arrested. He related that such extensive drinking may occur as many as three times a year. He usually drinks beer. If he is alone and stops for a drink he'll have one or two beers, but if he is with someone or knows someone in the bar he may have several. The wife usually consumes no more than ten drinks a year.

They seldom drink at home. Client indicates that he drank heavily while in service, every night, extensively. Beer was consumed until the money ran out.

He was busted in California for operating under the influence He hit a car. The incident cost him $2500 total. At that time he was living with a woman in California and they had engaged in a severe fight before this drinking episode.

He relates he is embarrassed to take his wife any place because of her appearance. He has threatened to leave and even struck her. Neither has encountered any professional counseling, but he feels it is worth the effort to get somebody who will try to help them both. He believes that the drinking is not the prominent problem at the present, but indicated he is fearful he may do more of it if the home situation is not alleviated somewhat.

Prior to his present employment which involves many and varied hours or work, he was self-employed. He considers himself a hustler, and from all indications has been exposed to and acquainted with many of the "pros." This includes gambling, and sales of various types.

INFORMATION FROM HOME VISIT

Family rents a well-kept, two-bedroom aluminum-sided home, which is comfortably furnished in relatively new furniture. Wife was cordial and the conversation was easy-going. Counselor explained program and asked why client had been interested in receiving counseling. Her reply was that he was interested in finding out what his problems were and how to solve them.

With a bit of encouragement and side conversation, the wife related the following information:
At the age of 6, his parents separated and soon after, his father died. He was raised, along with a brother, who is 8 years older than he, by his mother and aunt. After he got out of college, he started working as a salesman, which is his trade.

They were married 6 years ago. The first year of marriage was hard because client was not used to thinking about someone else, i.e., in not calling to tell her he would be home very late, etc. It was also then that his drinking was heavy and he spent night out with the guys.

They moved to Ohio on a different job at which point his drinking lessened a great deal. They then moved to Indianapolis.

In the last 6 years, he has started drinking heavily twice — the first year of their marriage and a few years ago. Her reaction to this was one of madness at the much-needed money that was being spent and fear for his well-being and her peace of mind. The second time, he went on a week's binge and then cried and asked for her to help him. She agreed to help him and said she would also try to get some outside help for him — but never did because they couldn't afford a psychiatrist. She said his drinking slowed down a great deal after that and has never gotten as great as before.

Now, when he drinks, he follows the blood-alcohol chart he received in DWI school and has gotten his friends to do the same. Now, when he comes home late from drinking, he blames her for things, i.e., her weight. He brings her weight up seldom when he has not been drinking. Although she has been just as heavy for the last 2-3 years, he has brought it up in the past year only. She is currently on a self-imposed diet. (In counselor's opinion, she is about 40 to 50 pounds over-weight) When they have sex after he has been drinking, he can't get physically excited sometimes and blames this on her weight. In relation to work, he has held no job over one year, usually quitting because of a "get rich scheme" or dissatisfaction with the job. In spite of his short work periods, he never has trouble getting another job. He is earning more now than he ever has and works 7 days a week on commission. Although this is usually a slow time of the year for sales, he is busier than ever. The wife worked before her pregnancy. It was during that time that the client quit his job and was slow in finding another one. She feels that if she starts working again, he will let her have all the financial burdens again. She enjoys staying at home, but regrets not having a driver's license to run the errands. She has never learned to drive and client does not have time to teach her. She doesn't feel they can afford private lessons.

Client has previously been involved in a burglary charge before they were married, about which the wife knows little, and a federal offense involving transporting pornographic films across the state lines to sell them. On the last offense, he still has one year's probation left (out of three). He will be able to get his driver's license in a few days, but has one more month of probation left for the OMVUIL offense.

MODULE 5: TREATMENT PLANNING

MODULE 5: TREATMENT PLANNING

Focus, Objectives & Resources

FOCUS

The process of treatment planning or developing a treatment program for a client should be highly individualized. In order to accomplish this, the counselor needs to work with the client on developing a realistic treatment regimen which is both therapeutic and responsive to the needs of the client. This module focuses on this fact and considers methods and strategies for turning intake data into therapeutic treatment programs.

During this process the participants will have the opportunity to participate in the development of criteria for making treatment decisions and have the experience of developing a treatment program as part of a treatment team.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- Identify three modes of treatment and explain the criteria for placing a client into that mode.
- State two advantages of treatment teams.
- Explain the advantages of negotiating a treatment plan with a client.
- State two reasons why programs must be flexible in their expectations of clients.

RESOURCES REQUIRED

The activities in this module will require:

- A trainer
- A large room
- Participants to bring their case studies from Module 4
- A small room for each facilitator
- A flip chart or newsprint and felt tip pens for each facilitator
- Masking tape
- A copy of the resource paper for each participant

MODULE 5: TREATMENT PLANNING

Learning Activity Schedule

Activity 1
(1 Hour)

Trainer Presentation

The trainer will make a presentation highlighting the major aspects of developing a treatment plan. The presentation will feature remarks concerning the necessity of mutual contracting between the counselor and client, the need for flexibility in the development of treatment plans, and the importance of the client's perception and self concept to goal setting. The presentation will be made in an interactive style, eliciting input and comments from the participants.

RESOURCES
REQUIRED

- A trainer
- A large room
- A flip chart and felt tip markers
- A copy of the resource paper for each participant

Activity 2
(2-2½ Hours)

Treatment Planning

Small groups reassemble as defined in Learning Activity Session number 2, Module 4. The participants will report the data they have identified as significant and state why. Following this, each group will compile on newsprint a list of the data which they, as a group, feel to be the information most relevant to intake and assessment procedures.

Next, the participants will construct a treatment plan for the case study on newsprint. In this experience, the participants will have the opportunity to interact as a clinical staff and discuss the case and the treatment plan in that context.

RESOURCES
REQUIRED

- A facilitator for each six-eight people
- A small room for each facilitator
- A flip chart or newsprint and felt tip pens for each facilitator
- The case studies from Module 4 for each participant

Activity 3
(30 Minutes to 1 Hour)

Treatment Plan Reports

In this activity, each small group by designated spokesperson will report its treatment plan to the training community. The spokesperson and members of each group will have the opportunity to explain the rationale for the proposed treatment program and the reasons for the specific modes of treatment chosen.

RESOURCES REQUIRED

- A trainer
- A large room
- Masking tape
- The case study treatment plans for each small group

MODULE 5 : TREATMENT PLANNING

Trainer Guidelines

Activity 1
1 Hour

The trainer, after reviewing the objectives for this module, will make a presentation on how to develop a treatment plan. A good strategy is to elicit imput from the participants. The focus should be on developing criteria on which to make treatment oriented decisions. It will be important to set the tone of rational, criterion-based decision making, as the participants will be asked to justify their treatment plans. The basis for building a treatment plan will be assessments made on the basis of the data gleaned during the intake process. The information highlighted by the groups in Module 4 will be instrumental in developing the treatment plan.

The trainer may refer to "Overcoming Dependence" which is the resource paper for Unit A, Module 6, as a reference for the types of behavioral goals which should be included in a treatment plan. By referencing the action statements or treatment goals identified in the article, the trainer can assist materially in the conceptual integration of the course. The major function of gathering intake data, then, is to provide information upon which to make assessments about the types of skills a client needs to develop. The selection and contracting of treatment goals should comprehend skill-development activities which will make up for the deficiencies indicated by the intake and assessment processes.

The development of adequate treatment goals must take into account the client's self-concept and perception of the situation. The trainer should make this point and reference the stages of self-concept development outlined in "A Conceptual Model of The Life Cycle of Addiction," one of the reference papers for Unit A, Module 5. Asking a client to contract for behaviors inconsistent with his/her self-concept is building failure into the treatment plan. The expectations for progress on the part of the client must take into consideration the client's own expectations and self-imposed limitations.

Activity 2
2 - 2 1/2
Hours

During this activity each group will construct a treatment plan for the person portrayed in the case study used in Module 4. The same groups which worked together in Module 4 should work together for this activity. The facilitator should initially require them to construct the treatment plan based on the data which was previously identified by that group as being significant. This will provide an operational self-check on the validity of the data points identified in Module 4. If this later becomes counterproductive, the facilitator should broaden the data base from which they are permitted to work. This should be done after the group has learned why their original data list was incomplete and, therefore, not fully effective.

The facilitator should not allow the group to evade the task because of complaints that they do not have enough data or that the client needs to be present in order to accomplish the task. Ask the group to develop a strategy to solve any such problems. Such strategies may include having a group member role-play the individual, making certain assumptions, or just defining certain limits within which to work.

There are no programmatic limitations within which the group have to work. They should construct the "ideal" treatment plan regardless of the program they work for. Each group should be required, by the facilitator, to justify each step of its treatment program.

Activity 3
30 Minutes
to 1 Hour

Each group will report its treatment plan to the entire community . During this process, each group will be accountable for each step in its plan, including the rationale or criteria upon which a decision was made. Such an accountability should be of the nature of the following example:

Q: Why did you put the client into group therapy?

A: Persons with characteristic X profit from group therapy, and this client has characteristic X. This is evidenced by fact Y which we learned from the intake information.

At the conclusion of the reports, other participants should have the opportunity to react to the experience. The role of the group in devising the treatment plan, the cogency of the rationale for the treatment decisions made and the personal responses to the process which participants may have are some of the issues which may be discussed.

MANAGEMENT OF CLIENT BEHAVIOR CHANGE

by

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MANAGEMENT OF CLIENT BEHAVIOR CHANGE

Helping people change their behavior has generally been viewed with skepticism in our culture. Periodic debate is heard in our government, colleges, and communities concerning whether we should lock people up, execute them, or rehabilitate them. Regardless of who won the individual debate, our nation has created a vast array of institutions to help people change their behavior which is either unacceptable to the individual or to society or to both. We have reform schools, prisons, rehabilitation centers, schools, job training programs, behavior modification centers, methadone clinics, The Salvation Army, Boys' Clubs, Rescue Missions, Alcohol Recovery Centers, Drug Abuse Centers, Weight Watchers, and Alcohol Anonymous.

The public, while continuing to support such programs, experiences the same problems in their communities: crime in the streets, drug trafficking, drunk driving, child abuse, unemployment, and suicide attempts. Although success rates vary from program to program, most can boast of only minimal achievement for their clients if meaningful and permanent behavior change is seen as their goal. How is it that we can send people to the moon and can't seem to help the majority of the 10-12 million alcoholics in this country? We could blame it on lack of money, society, or the alcoholic himself, and perhaps rightfully so. However, in terms of our roles as counselors, to do so often affords each of us a cop-out from critically and analytically assessing how we can improve the quality control of our product (behavior change).

In focusing on how we can improve the quality of our product, we need to examine the machine which produces our product: ourselves. There are two primary skill areas in which counselors need competency. One is the delivery of face-to-face counseling services. Most of us have devoted some time to the understanding and development of such face-to-face skills. Many of us have attended a myriad of workshops including interviewing, self-awareness, encounter, communication skills, and empathy development. In fact, many of us actually "get our kicks" from and enjoy the face-to-face aspect of counseling. However, we often overlook the second or "other" skill area necessary for facilitating client behavior change, that of managing the total change process.

Management of the change process of our clients is no easy task. It requires tremendous self-discipline as well as a thorough knowledge of each client, of program and community resources, and of how clients change their behavior. It involves managing our clients' movement from intake, through treatment or (re)habilitation, to aftercare. In the momentary intensity of counseling situations, we often get lost "in the here and now" and forget our management function as a counselor. In this paper I will explore the management function of a counselor, focus on the issues which are integral to sound client management and examine the procedure for managing a client's growth.

Our role as a manager of a client's growth process gives us the responsibility not for our clients' actions but for guiding our clients along a path where they consider the roadblocks of their dilemma, make their own behavioral decisions, and take responsibility for carrying out those decisions. We are responsible for making sure our client has identified what it is about himself that causes him to lose every job he gets, has explored all the behavioral options he has to resolve his problem of being fired, and has developed an action plan of what he can do to keep his present job. We are responsible for moving our client through such a process and must be invested in each client's process but not his behavior. To invest ourselves in his behavior assumes that the client is not responsible for himself and leads only to frustrations for both ourselves and our client.

An important factor which is crucial to the success of client management is the client's investment in his own change process. Management (Blake-Mouton, MacGregor) says that for maximum results or goal attainment a manager should allow the employee (client) to do work which the employee has determined to be meaningful (by involvement in the planning process) and has responsibility for. Thus, a client, who determines his own problem, chooses his own behavior to solve the problem, and takes responsibility for that behavior, will increase the probability of achieving his goal.

In guiding a client's process, another factor which many times "makes or breaks" a client is the amount of stress which we allow the change process to place upon the client. A body-building instructor knows that a weight lifter who can lift only 150 pounds today cannot realistically lift 300 pounds tomorrow. The instructor will devise a step-by-step approach to gradually increase the weight capacity of the lifter from 150 to 300 pounds. Such a process may take months or even years. The instructor knows the key to reaching a goal is to introduce his lifter to gradually increasing amounts of stress. To move from 150 pounds to 300 pounds in one step would insure failure and perhaps permanently damage the lifter. Our role as managers of growth processes requires us to introduce enough stress to allow our clients to grow as quickly as possible but not to the point of dooming them to failure. Poorly managed stress inducement many times results in reinforcement of an already negative self-concept.

Many systems have been developed for client management in the helping professions. These systems vary in degree of complexity and level of sophistication. Which is the best? It varies with programmatic needs. I would urge each of you to use whatever system best fits your own management needs. A multitude of variables is instrumental in determining what system would best fit your program. Often external relationships with funding sources, program licensure agencies, accreditation bodies, referral sources, or supportive services will require certain types of management systems. Internal program variables may include number of clients served, type of program, size and skill of staff members, reporting requirements of your agency, and evaluation/statistical needs of your program. No matter what your program variables are and what management system your program develops or adopts, there are five functions common to all management systems. The five functions are:

(1) data collection and assessment
(2) development of treatment or growth plans which include
    a. long-term goals
    b. short-term goals
    c. strategy for accomplishing the goals
(3) periodic review of client progress in attaining goals
(4) termination
(5) aftercare

Different terminology or labels may be used for the five functions but the function is the same. These five functions are consistent with federal and state requirements for programs. The functions are sequential with each function needing completion before proceding to the next.

DATA COLLECTION AND ASSESSMENT

The data collection and assessment function is described in "Criteria For Selecting Client Intake Data" (Salisbury, 1976). It is important to note that no matter how intensive and thorough data collection may be, the assessment function should not be considered complete until the data is grouped according to the corresponding skill area, i.e., intrapersonal, interpersonal, or situational. The skill areas for each client should then be assessed in terms of what skill areas are satisfactory and which are deficient.

DEVELOPMENT OF TREATMENT OR GROWTH PLANS

After the assessment function is complete, we can then begin to develop growth plans for each client. We should keep in mind that a considerable amount of time (possibly a month) may be required for data collection and assessment. Realistic growth plans cannot be developed from a one-hour intake session. If we approach counseling from a wholistic perspective and understand the importance of establishing an empathic and explicit relationship with the client, then the probability that data assessment will serve as a firm foundation for our treatment planning is greatly enhanced.

It may be often necessary to satisfy immediate needs of the client such as medical care, food, or housing before data assessment can be completed. "Get the client out of the weather before you build his mansion."

In addition to the three habilitation skill areas, we should review the other four characteristics of dependent people as we are developing a growth plan with our client. Of these four characteristics, three relate directly to the process of growth planning. Faith in miracle solutions to problems can be replaced by faith in problem-solving processes. If the client is involved in the development of his own problem-solving process (growth planning) and experiences some level of success with such a process, then he will develop faith in it. We are also teaching a client how to take responsibility for his family processes by giving him responsibility in his own growth process. The client will also develop judgemental skills and be better able to recognize, understand, and apply relationships if he is prodded to do so while in counseling.

The fourth characteristic of a dependent person, which we should consider in developing a growth plan, is "Does our client have viable role models?" Are there any persons presently in our client's life from whom he can learn positive life skills by modeling their behavior? If not, we should strongly consider including the development of such relationships in the client's growth plan.

Long-term and short-term growth goals should be developed in accordance with the client's dependency characteristics and skill needs. The growth goals should exhibit two characteristics:

(1) The goals should specify what the client will do, by when, and under which conditions.
(2) They should be measurable and observable both by the client and the counselor.

For each long-term goal developed, there should be accompanying short-term goals whose achievement leads to the achievement of the long-term goal. For every short-term goal there should be corresponding strategy which leads to its attainment. Figures 1 and 2 illustrate the flow and the building process for the development of growth plans and for the accomplishment of growth plans, respectively.

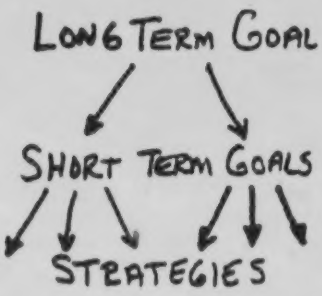

Figure 1. Development of Growth Plan

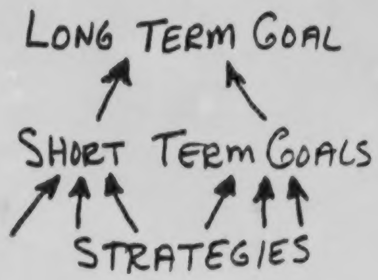

Figure 2. Accomplishment of Growth Plan

In the development of adequate treatment goals, we must take into account the client's self-concept and perception of her situation. Asking a client to contract for behavior inconsistent with her self-concept is building failure into the growth plan. If a client views herself as a junkie and has values consistent with the junkie subculture, it will be nearly impossible for her to achieve growth goals which assume she has values and desires behavior which are consistent with "square" society. The client's position in the life cycle of addiction should be determined before goals can be developed (see "A Conceptual Model of the Life Cycle of Addiction" by Brill, Alksne, and Liebemen).

With a client's self-concept and her dependency characteristics critically assessed, goals and strategy should be developed which the client can actually accomplish. Often we forget that the client with whom we work out goals and strategy for getting herself a job does not have "it together" enough to get out of bed in the morning. The goals and, especially, the strategy should reflect precisely how much stress or change a client can handle without failure.

REVIEW OF CLIENT PROGRESS

Once we have developed goals and strategy for our client, there should be a periodic review of a client's progress in attaining his goals. This is best done in a team setting. Every staff member who delivers direct services to the client should be a part of the team as should be the person in charge of clinical services, of other services, and of other counselors. We, as the manager of our client's process, should be in charge of such a team case review and should elicit feedback from the rest of the team. Such a team review can serve three purposes:

(1) We may receive information or ideas from our fellow team members which will give us additional insight into our client's progress or lack of progress.
(2) We may have our perceptions of our client's progress validated and become more confident as managers of a growth process.
(3) It can improve continuity of services delivered by the program and prevent "picking off" of staff members by manipulative clients.

After receiving input from team members, a decision should be made as to whether client progress is satisfactory and whether or not the goals and strategy should be revised. If revision is necessary, the client should be included in the process.

TERMINATION

The process of ending a relationship requires as much energy as building a relationship. As a manager of a client's growth, it is critical that we are aware of the importance of the termination process. Clients and counselors often become dependent on each other. The client has frequently shifted her dependency from substance to counselor. As the client nears attainment of her goals, the growth plan should include a "weening" from the counselor and a taking of responsibility for management of her own growth process. Hopefully, she should have developed the skills necessary for her self-management during the growth process.

If goals were specific, measurable, and observable, it should be easy to determine when to terminate a client. If we and the client know what it was that she wanted to achieve and why she wanted to achieve such a goal, the criteria for successful termination would be cut and dry.

Included in every termination should be a final review of the client's growth process while in the program. This insures the permanence of behavior change by conceptualizing what the client has already felt and done.

AFTERCARE

National statistics concerning substance abuse programs show that the point at which most clients loose control of their substance usage occurs shortly after they are terminated from a program. This implies that we as counselors must place greater importance upon aftercare planning for the client. If the client has developed the skills during treatment which are necessary for managing her life, she should be able to develop an aftercare plan for herself which considers all the contingencies of re-entry into community life. We should be responsible for making sure that every client has developed such a plan which both the client and ourselves view as realistic.

Included in the plan should be scheduled contact between client and program. It is important that the client understand that she has the option of returning to the program for support if she deems it necessary. She should also feel that she will be accepted by the counselor and the program if she does return for support.

It is imperative at the conclusion of a client's involvement with a program that the client has come to view change as a process and not an event. Having control over substance usage is not something that occurs overnight but it is a skill-building process. Clients who understand this at the termination of treatment have a much greater probability for gaining control over their behavior.

MODULE 6: CONFIDENTIALITY AND ETHICAL CONSIDERATIONS

MODULE 6: CONFIDENTIALITY AND ETHICAL CONSIDERATIONS

Focus, Objectives and Resources

FOCUS

This module reviews two fundamental aspects of the counseling relationship -- confidentiality and the ethical considerations which arise in a therapeutic situation. A review of the Federal Regulations governing the confidentiality of client records is coupled with a group consideration of the ethical issues involved in helping an individual to restructure his/her life.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- Outline the major aspects of the Federal Regulations on the Confidentiality of Alcohol and Drug Abuse Patient Records.
- State three ethical considerations for substance abuse counselors.

RESOURCES REQUIRED

The activities in this module will require:

- A trainer
- A large room
- A flip chart and felt tip pens
- A copy of the Federal Register of July 1, 1975 entitled "Confidentiality of Alcohol and Drug Abuse Patient Records," for each participant.
- A copy of the two resource papers for each participant
  "Federal Register"
  "Confidentiality"

MODULE 6: CONFIDENTIALITY AND ETHICAL CONSIDERATIONS

Learning Activity Schedule

Activity 1
1 Hour

Confidentiality

This activity consists of a trainer presentation and question and answer session on the Federal Regulations governing the confidentiality of client records.

RESOURCES REQUIRED

- A trainer
- A large room
- A copy of the Federal Register of July 1, 1975 entitled "Confidentiality of Alcohol and Drug Abuse Patient Records," and a copy of "Confidentiality from Assessment Interviewing for Treatment Planning Training Manual" for each participant
- A flip chart and felt tip pens

Activity 2
45 Minutes

Ethical Considerations

Small groups of six-eight persons are formed to process (EIAG) the Confidentiality presentation. When this is completed, each small group facilitator introduces the subject of ethical considerations affecting the client-counselor relationship. Speaking from his own personal experience with ethical dilemma,may be an effective way to help clients identify their own ethical concerns.

RESOURCES REQUIRED

- A facilitator for each small group
- Small rooms for each six-eight persons

MODULE 6: CONFIDENTIALITY AND ETHICAL CONSIDERATIONS

Trainer Guidelines

Activity 1
(1 Hour)

Based on the Federal Register and National Drug Abuse article on confidentiality, the trainer will make a presentation on the confidentiality of client records. In gray areas, the confidentiality of the records should take precedence in the comments of the trainer. Encouragement should be given to participants to periodically review the regulations and to discuss them with their program personnel. The serious legal implications of violation of these regulations should not be ignored.

Activity 2
(45 Minutes)

The small group facilitators should construct this session however he/she sees fit. Many participants will have comments in this area. Some issues which should be looked at are:

1. The role of control and coercian in counseling.
2. The ramifications of sexual involvement.
3. The use of positive and negative manipulation techniques and the difference between the two.
4. The setting of behavioral standards for others.

CONFIDENTIALITY

From NDAC, *Assessment Interviewing for Treatment Planning--Training Manual*. Rosslyn, VA: National Drug Abuse Center for Training and Resource Development, 1976.

CONFIDENTIALITY

It has always been one of the counselor's major responsibilities to develop a relationship with the client that is conducive to self-disclosure and to assure the client that that information will be held in the strictest confidence.

The establishment of a trusting counselor-client relationship is appropriately discussed in the sections concerning the development of interviewing skills. There are, however, sensitive areas that are best covered here. A clear understanding of these areas will offer you insight into the nature of your work, help you develop more realistic expectations, and provide a reference point to measure progress. The information that you need from a client may be psychologically sensitive (certain issues may be painful to face or discuss); it may also create personal dangers due to the possibility of reprisals in the streets or of prosecution by the courts.

A client is sometimes reluctant to divulge personal information because he fears disclosure or a breach of confidentiality. Such fears are easily understandable, but must be allayed if treatment is to be effective. The client should be aware that firm regulations exist to protect both clients and professionals. A mark of a good counselor is the ability to develop a trusting relationship in spite of these constraints.

The type of information generated and recorded by drug abuse treatment programs is frequently of a confidential nature; therefore, the potential exists for violating a client's rights to confidentiality. Counselors learn a great deal about a client's personal life during the treatment process. Developing case histories and treatment plans on the basis of the Assessment Interviewing Guide increases the potential for violating confidentiality, since a good case history contains a great deal of information of a personal and highly sensitive nature. The use of case histories and treatment plans implies that such information will be entered in written form. Because of this, it is important that the client understand how this information is legally protected and how the treatment facility ensures this protection.

Current rules and regulations, *Confidentiality of Alcohol and Drug Abuse Patient Records, General Provisions* (**Federal Register**, Vol. 40, No. 127, July 1, 1975), provide you with legal support for dealing with the client's misgivings.

Your responsibilities with regard to the client's records lie in two areas: (1) the use, storage, and security of written records, and (2) the protection of information from illegal (and/or unethical) oral disclosure. Responsibility in the first area is straightforward: you must be accountable to the staff person charged with maintaining and securing client records. The project must have a storage and acquisition system that satisfies Federal laws and regulations. Since many project components will use the clients' records (counseling for treatment, other components for cost analysis, billing, job training), a well organized and well run recordkeeping system is essential. You, as one of many who records and utilizes information, must observe project policies and procedures in keeping records.

The second area of responsibility is perhaps not so easy to fulfill; seemingly inconsequential conversations could result in the unintentional but nevertheless illegal disclosure of confidential information. A client may only be discussed during actual treatment consultation and then only with appropriate staff persons. While the confidentiality regulations are very explicit and quite strict on the subject of oral disclosures, you are also bound by your own moral code and professional standards of conduct (such as those developed by the American Psychological Association or other professional organizations in human services). In essence, *professional standards require that you act on behalf of the client and behave in the client's best interest.*

The Federal regulations apply to all records of identity, diagnosis, prognosis, or treatment and "include any information, whether recorded or not, relating to a patient . . ." (p. 27805 [11]).* Such information includes facts pertaining to attendance, physical whereabouts, and to the client's status. In general, the best policy is to simply decline any discussion about a client unless proper written authorization is obtained.

Since the project director is legally responsible for the project, it is not necessary for a counselor to respond to any request for disclosure of patient records or information; this includes subpoenaed information or information sought by coercive means. If a director orders you to provide information, either written or oral, it is certainly to your advantage to have the order put in writing.

The client's permission to divulge information must be in the form of a *written* consent in all except extraordinary circumstances, such as medical emergencies or by specific court order. Even in cases where information may be obtained without written consent, there are strict regulations governing the nature and extent of the disclosure. To protect oneself and the client, the best policy is to obtain a written release. Once such consent is obtained, however, it should be turned over to the records manager whose duty it is to maintain such releases as part of the client's records.

Information is occasionally sought through secret or covert means. Those seeking the information may be law enforcement officials, creditors, or persons with extra-legal intent. In general, confidentiality regulations prohibit the use of undercover agents and informants in drug abuse programs, or the disclosure of information to such individuals. It goes without saying that disclosures not associated with law enforcement agencies are equally prohibited by and subject to the regulations.

In summary, confidentiality means two things for you: developing a relationship of confidence with the client, and maintaining records with such professional decorum that nothing, either spoken or written, is handled in such a manner that would violate that confidence (or the law).

A synopsis of the confidentiality regulations, which were set forth as part of the Drug Abuse Office and Treatment Act of 1972 and further amended in July of 1975, is presented on the following pages. The reader is warned not to consider himself an expert when he completes this section. On the contrary, any questions concerning these regulations should be handled by a lawyer. It is our intention here to give you sufficient information to know that a lawyer should be consulted.

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*Department of Health, Education and Welfare, and Special Action Office for Drug Abuse Prevention. Confidentiality of Alcohol and Drug Abuse Patient Records. **Federal Register**. Friday, July 1, 1975, 40 (127).

CONFIDENTIALITY OF DRUG ABUSE PATIENT RECORDS

In the area of drug abuse, most records of treatment are entitled to strict confidentiality and nondisclosure. Under 21 U.S.C. 1175, Section 408, of the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), records of the "identity, diagnosis, prognosis, or treatment of any patient" in relationship to drug abuse treatment in hospitals receiving *any* type of Federal assistance must be kept confidential unless specific exemption of the act allows disclosure.

In its legislative report on the 1972 Drug Abuse Act, Congress states:

> Every person having control over or access to patients' records must understand that disclosure is permitted only under the circumstances and conditions set forth in this section (21 U.S.C. 1175). Records are not to be made available to investigators for purpose of law enforcement or for any other private or public purpose or in any manner not specified in this section.

Recently, the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention (SAODAP) promulgated new detailed regulations interpreting the extent of this mandate for confidentiality of patient records. In the preamble to these regulations, HEW and SAODAP reiterated Congress' view that disclosure of patient records was to be limited so as to diminish any impediments to voluntary treatment for drug abuse. A copy of the Special Action Office regulations may be found in Appendices; it should be consulted for information regarding specific situations. Some highlights of these regulations are:

- Appropriate precautions must be taken to provide security for patients' files dealing with drug abuse treatment. Records shall be kept in a secure room, locked file or similar container. Written procedures should be in effect to regulate and control access to such files.
- These regulations apply to any given individual over any period of time, irrespective of commencement date, provided the treatment did not end before March 21, 1972, in the case of drug abuse, and before May 14, 1974, in the case of alcohol abuse. The records of a person whose application is rejected or withdrawn are fully as much covered as those of active patients.
- Any disclosure should be limited to the extent required to serve a lawful purpose or bona fide cause (e.g., medical emergency). In essence, this means that the only information that should be released is that which is necessary to bring about the successful conclusion of the purpose for which the information is being released. Hence, blanket disclosures of all records should be discouraged; only records pertinent to the cause for disclosure should be released.
- The prohibition upon unauthorized disclosure applies whether or not the person seeking the disclosure already has the information, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other basis for disclosure not expressly authorized in the regulations.
- Such prohibition covers all information including attendance, the patient's status in the program, and physical whereabouts of the patient. The disclosure of negative information (e.g., whether an individual is not or has not been attending a program) is equally prohibited.

Disclosure with the Patient's Written Consent

The Drug Abuse Office and Treatment Act does allow disclosure with the patient's *written* consent. A patient's record, identity, diagnosis, prognosis and details of treatment should not be divulged to any Federal, state or local authorities (except for purposes of research, audit, and/or evaluation) without such consent. For example, a telephone call alerting the police to the drug abuse would violate this regulation and thereby violate the law.

The patient's written consent is required in any of the following situations:

- For any disclosure of treatment information to parole or probation officials and/or court officials (If, however, participation in treatment is a condition of pretrial or posttrial release, the patient may consent to unrestricted communication between the program and the court and probation and parole officials.)
- For any disclosure of information to the patient's attorney
- For disclosures to medical personnel or to treatment or rehabilitation programs
- For disclosures to third party payers and funding sources
- For disclosures to family or individuals with whom the patient has a responsible personal relationship
- For any disclosure to employers and employment agencies (In the case of information to a prospective employer, the following conditions must be met: (1) The patient must submit a *written* and *signed* request that identifies the prospective employer. (2) The person supplying the information must verify the request with the prospective employer. (3) The information supplied must be limited to the extent that it meets (but does not exceed) requirements of the purpose for which it is being furnished. (4) No information shall be furnished unless there is credible belief that the information is to be used for the drug abuser's rehabilitation.)

In any situation not otherwise specifically provided for in these regulations, where written consent is given in accordance with the regulations, disclosure may be made for the benefit of the patient if all of the following criteria are met: (1) There must be nothing in the written consent or the circumstances surrounding it to indicate that the consent was not given freely and without coercion. (2) Such disclosure must not cause harm to the patient. (3) Such disclosure should not be injurious to the program-client relationship. The program director has final responsibility in determining if these criteria have been met and whether disclosure should be made,

Circumstances considered to be beneficial to a patient include, but are not limited to, those in which the disclosure may be of assistance to the patient or his immediate family. Examples include welfare, Medicare, unemployment, workmen's compensation, insurance benefits, pension or retirement benefits, and issues pertaining to the patient's interests in any civil, administrative, or other legal proceeding.

In a form for consent to disclosure, the following eight items are required:

- The name of the patient about whom information is being disclosed
- The name of the program making the disclosure
- The name(s) of the person(s) to whom the information is to be disclosed
- A written and dated release for the disclosure of the information
- The signature of the patient or other authorized party granting permission to release information

  (General releases, signed prior to specific requests for information, for example, the type of release required prior to receiving treatment, are not acceptable.)
- A statement of the purpose and need for disclosure
- A description of the extent and nature of the information to be disclosed
- A statement that the consent may be revoked at any time by the patient and a specification of the date, event, or condition upon which it will expire without expressed revocation

  (Any redisclosure normally requires the further specific consent of the patient, and is subject to the same restrictions governing the original disclosure.)

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Consent with Respect to Minors and Incompetent or Deceased Patients

Consent must be given by both the minor and his parent, guardian, or other legally authorized person; any disclosure made after the patient has ceased to be a minor may be consented to only by the patient. In states where treatment is authorized without parental consent, any consent required for disclosure may be given only by the patient.

In a situation where a state requires parental consent and a minor applies for treatment on his own behalf, the fact of such application may not be disclosed to his parents or guardians without his consent. If the applicant refuses such consent, it must be pointed out that he cannot receive services without it.

In states where parental consent is not required for treatment, no inquiry may be made regarding the financial status of the patient's family, nor may any bills or requests for payment be sent, directly or indirectly, to the patient's family or guardians without the written consent of the patient. Such consent may not be made a condition for receipt of services except in the case of a program that is not required by law to furnish services irrespective of ability to pay and does not in fact hold out itself as willing to furnish such services.

If a minor lacks the rational capacity to give consent (either due to extreme youth or mental or physical incapacitation), disclosures may be made to parents or guardians in situations that pose considerable danger to the patient or applicant. The law states:

> When, in the judgment of a program director a minor applicant for services, because of extreme youth or mental or physical condition, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, and the situation of the applicant poses a substantial threat to the life or physical well being of the applicant or any other individual, and such threat might be reduced by communicating the relevant facts to a parent or guardian of the applicant, such facts may be so communicated by the program director or by program personnel authorized by the director to do so. (Section 2.15f)

In the case of incompetents other than minors, consent may be given by legal guardians. The law states:

> Where consent is required for any disclosure (for incompetent patients other than minors) . . . such consent in the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs may be given by the guardian or other person authorized under State law to act in the patient's behalf. (Section 2.16a)

Consent for disclosure of information pertaining to deceased persons may be given by an executor, administrator, or other personal representative. In the absence of such representatives, consent may be given by the spouse or, if none, by any responsible member of the patient's family. Any disclosures required by Federal or state law pertaining to death or other vital statistics may be made without consent.

Disclosure to Third Party Payers

A third party payer is defined as any organization or acting agent that pays or agrees to pay for diagnosis or treatment where such payment is on the basis of an individual relationship between the payer and the client or a member of the client's family (in the case of insurance coverage) as set forth by a contract, insurance policy, or similar documents.

Disclosures may be made to third party payers and funding sources only with the written consent of the patient; only information that is necessary for the fulfillment of legal or contractual obligations on the part of such parties may be given. Any information acquired by such parties is subject to the same restrictions covering original disclosures.

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Disclosures without Patient's Written Consent

Although the best general rule of thumb to follow regarding disclosures is to obtain written consent whenever possible and for almost all situations, there are a few circumstances under which disclosures may be made without the patient's written consent. If written consent is not given, disclosure is allowed:

- When it is necessary for medical personnel to meet a medical emergency
- When it is authorized by a court order (accompanied by a subpoena), in which case information shall be limited to objective data necessary to meet the purposes for which the order is intended
- When treatment involves the use of any drug determined by the FDA to be dangerous to the life or health of the patient, in which case patient identifying information may be released to the FDA for purposes of notifying patients or their physicians
- For scientific research, management and financial audits, or program evaluation, but without disclosing in any report of such research, audit, or evaluation the identity of the drug abuser

In situations where oral disclosures are made without consent but in accordance with the regulations governing disclosure without patient consent, the program is to provide a written memorandum giving the patient's name, the nature of the emergency, the date and time of disclosure, the nature of the information disclosed, and the names of the individuals making and receiving such disclosures.

The Use of Central Registries

In certain areas of the country, central registries play an important part in treatment programs. The use of such registries, however, is prohibited unless they meet the definition of a permissible central registry and their use is for the purpose of preventing multiple enrollments in drug maintenance or detoxification programs. A "permissible central registry" is defined as a service organization that collects patient identifying information from two or more programs within the same state or not more than 125 miles from the nearest border of such state.

Information Obtained through Supervisory and Regulatory Processes

The following agencies are permitted access to program premises and records for the purpose of carrying out their specific functions in the supervision and regulation of drug maintenance and methadone detoxification programs: (1) Drug Enforcement Administration; (2) Food and Drug Administration; (3) state drug law enforcement agencies; and (4) state health authorities. (Other agencies, for example, funding agencies, may be granted access to records for purposes of audit and evaluation so long as this transaction is consistent with Sections 253 and 254 of the regulations.)

Patient identifying information obtained through these supervisory and regulatory processes may not be used in any registry or personal data bank of any sort, nor may it be otherwise disclosed.

Undercover Agents and Informants

Due to legal circumstances surrounding drug abuse, many patients enter treatment programs with a great deal of anxiety and suspicion. Consequently, the presence of undercover agents and informants can exercise considerable negative effects on program morale and effectiveness. In addition, the purpose of such agents is generally to secure information of the type protected by this legislation.

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For the reasons indicated above, no undercover agents or informants may be employed or enrolled in any drug abuse treatment program, nor may the agent's supervisor knowingly permit the infiltration of such programs; the use of informants is equally prohibited. An informant may, however, enroll in a treatment program as a client for his own benefit.

Since there is always a possibility that medical personnel may become involved in the illegal sale of drugs, an exception to the above prohibitions is provided in order that sufficient evidence may be obtained for successful prosecution. In the case where criminal conduct is believed to be carried on by an employee of the program with the program director's knowledge of involvement, a court order may be issued without notice authorizing the use of undercover agents and informants.

Conclusion

All efforts should be made to maintain patient records in the utmost confidence. When there is a need for disclosure, written consent is almost always required with the exception of situations noted specifically in this section. When in doubt, obtain a written consent for the protection of both you and the patient.

It should be kept in mind that the restrictions and prohibitions set forth apply to all personnel, both while in the program and after leaving employment. The same restrictions apply to all outside parties associated with the program (e.g., auditors, researchers, evaluators, third party payers, service organizations) and who are recipients of disclosures. In like manner, redisclosure by individuals within the program or by those associated with the program is protected by the same set of regulations governing original disclosures; the patient's consent is ordinarily needed for each subsequent disclosure. The regulations also require that generally when a disclosure of information is made, the information should be accompanied by a statement informing the recipient of his obligation to guard the confidentiality of the information and not to disclose it except as authorized by the regulations.

Any violations of these laws or regulations, according to provisions made by Congress, can result in penalties of not more than five hundred dollars ($500.00) for the first offense, and five thousand dollars ($5,000.00) for each subsequent offense. Subsequent offenses need not be identical to the first violation but can pertain to any violation under this section.

federal register

TUESDAY, JULY 1, 1975

WASHINGTON, D.C.

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PART IV

THE NATIONAL ARCHIVES OF THE UNITED STATES • 1934 •

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

■

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

General Provisions

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U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND
MENTAL HEALTH ADMINISTRATION

Title 42—Public Health

CHAPTER I—PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER A—GENERAL PROVISIONS

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

On May 9, 1975, the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention published in the FEDERAL REGISTER (40 FR 20522) a notice of proposed joint rulemaking setting forth a proposed new Part 2 of Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records.

Interested persons were invited to submit written comments, views, or arguments with respect to the proposed regulations within 30 days of the date of publication of that notice. All comments so submitted were carefully considered, and at various stages in the rulemaking process, the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected by the proposed regulations were consulted.

As finally adopted and set forth hereinafter, the regulations contain two major substantive changes from the May 9 proposal. The separate treatment of funding sources and third-party payers (§§ 2.21 and 2.37 of the proposed regulations) was abandoned as unworkable, primarily because the prohibitions which the proposed regulations would have placed on funding sources would have directly conflicted with requirements which have been proposed in implementation of Title XX of the Social Security Act (see proposed 45 CFR 228.63, 40 FR 16802, 16809, April 14, 1975). In lieu of this approach, § 2.37 has been revised to provide that funding sources and third-party payers maintaining drug or alcohol abuse patient records are subject to restrictions upon disclosure to the same extent and in the same manner as any other entity maintaining records which are within the scope of the authorizing legislation and this Part.

The other major change is in the area of criminal justice system referrals, and the grounds for the rules finally adopted are set forth in the basis and purpose section (§ 2.39-1) pertaining thereto. In connection with that change, it must be frankly acknowledged that the arguments set forth in the corresponding basis and purpose section (§ 2.40-1) of the May 9 proposal have merit. The final rule may in certain instances result in a compromise of the treatment process, if judges or other authorities in the criminal justice system overreact to information whose communication is allowed under the final rules but would have been prohibited under the proposed rules.

Against such an adverse effect, however, there must be weighed the very real advantage which genuine cooperation between community social service systems and the criminal justice system can yield for those whose lives are crippled and scarred by the consequences of their own criminal conduct. Governmental responses based on a pure medical model have not met with noticeably greater success than those based on a purely punitive approach, and it would be tragic if these rules were so constructed as to become a barrier to the development of better ways to deal with those who are caught up in a pattern of seriously antisocial behavior.

In addition to the foregoing major changes, the following minor policy changes were made.

Provisions relating to destruction or other disposition of records were dropped from § 2.21 (§ 2.22 in the May 9 proposal) as unnecessary except in the case of programs discontinuing operations.

The fixed limitation on the permissible duration of written consent for disclosure was dropped from § 2.31 in favor of a limitation to such duration as may be reasonably necessary to effectuate the purpose for which the consent is given.

The specification of crimes in § 2.65 for which a court order may be granted authorizing use of program records in the investigation or prosecution of a patient was broadened to cover any "extremely serious" crime, with those listed in the May 9 notice being retained as examples.

Finally, a number of clarifying, technical, and conforming changes were made in the May 9 proposal, but these are without significant substantive effect.

Accordingly, pursuant to the authority of section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended by Pub. L. 92-282 (21 U.S.C. 1175), and section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended by Pub. L. 93-282 (42 U.S.C. 4582), and under the authority delegated to the General Counsel of the Special Action Office for Drug Abuse Prevention (39 FR 17901, May 21, 1974), Subchapter A of Chapter I, Title 42, Code of Federal Regulations, is amended by inserting immediately after Part 1 thereof a new Part 2 to read as set forth below.

Effective date. These regulations shall be effective on August 1, 1975.

Dated: June 25, 1975.

R. MOURE,
Acting Assistant Secretary for Health, Department of Health, Education, and Welfare.

Approved: June 26, 1975.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

Dated: June 27, 1975.

GRASTY CREWS II,
General Counsel, Special Action Office for Drug Abuse Prevention.

Dated: June 27, 1975.

ROBERT L. DUPONT,
Director, Special Action Office for Drug Abuse Prevention.

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2.67-1 Undercover agents and informants—basis and purpose.

Subpart A—Introductory Statement

§ 2.1 Statutory authority—drug abuse.

(a) *Statutory provisions effective May 14, 1974.* Insofar as the provisions of this part pertain to any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research, such provisions are authorized under section 408 of Pub. L. 92–255, the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) as amended by section 303 of Pub. L. 93–282 (88 Stat. 137). That section reads as follows:

§ 408. Confidentiality of patient records.

(a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (c), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) ~~To medical personnel~~ to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) The Director of the Special Action Office for Drug Abuse Prevention, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Director are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(b) *Amendments effective June 30, 1975.* Effective on the date specified in section 104 of the Drug Abuse Office and Treatment Act of 1972 (June 30, 1975), the first sentence of section 408(g) above, will be amended by striking "Director of the Special Action Office for Drug Abuse Prevention" and inserting in lieu thereof "Secretary of Health, Education, and Welfare", and the second sentence of such section will be amended by striking "Director" and inserting "Secretary" in lieu thereof. Also effective on that date, section 408, above, will be further amended by (1) striking out "The" and inserting in lieu thereof "Except as provided in subsection (h) of this section, the" in the first sentence of subsection (g) of such section; and (2) adding at the end of such section the following new subsection:

> (h) The Administrator of Veterans' Affairs, ~~through the Chief Medical Director~~, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations established by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from drug abuse. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

§ 2.2 Statutory authority—alcohol abuse.

Insofar as the provisions of this part pertain to any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, such provisions are authorized under section 333 of Pub. L. 91–616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582), as amended by section 122(a) of Pub. L. 93–282, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (88 Stat. 131). As so amended, that section reads as follows:

CONFIDENTIALITY OF RECORDS

SEC. 333. (a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(h) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations prescribed by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from alcohol abuse or alcoholism. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

§ 2.3 Previous regulations as controlling authority.

Attention is called to the interpretative regulations, issued by the Special Action Office for Drug Abuse Prevention (37 FR 24636, November 17, 1972, as revised 38 FR 33744, December 6, 1973, referred to hereinafter in this part as the "previous regulations"). Those regulations have been given a special status as controlling authority by the provisions of section 303(d) of Pub. L. 93–282, as well as the references in the legislative history of that act to the precedents established under section 408 of Pub. L. 92–255. Such references appear at page 11 of House Committee Report No. 93–759 and at page H3563 of the Congressional Record for May 6, 1974. The latter citation is to a detailed analysis of the bill in its final form which was submitted for the Record by its floor manager, Chairman Staggers of the Interstate and Foreign Commerce Committee, when the bill was up for final action by the House of Representatives.

§ 2.4 General purposes.

(a) *Policy objectives.* The purpose of the regulations set forth in this part is to implement the authorizing legislation in a manner that, to the extent practicable, takes into account two streams of legal thought and social policy. One has to do with enhancing the quality and attractiveness of treatment systems. The other is concerned with the interests of patients as citizens, most particularly in regard to protecting their rights of privacy. Within each stream there are cross-currents, and it should come as no surprise that areas of turbulence are to be found at their confluence.

(b) *Limited purpose.* The regulations contained in this part are not intended to direct the manner in which substantive functions, such as research, treatment, and evaluation, should be carried out, but rather to define the minimum requirements for the protection of confidentiality of patient records which must be satisfied in connection with the conduct of those functions in order to carry out the purposes of the authorizing legislation. This does not mean that observance of only the minimum legal requirements is always the wisest course, but in framing these regulations, allowance has necessarily been made for a diversity of emphasis and approach in the many different jurisdictions and by the great variety of public and private agencies which must find a way to function within the limits here prescribed.

§ 2.5 Format.

(a) *Basis and purpose sections.* Each section setting forth rules on any given topic in Subparts B through E of this part is followed by a section setting forth their basis and purpose. In many cases, the basis and purpose section is itself an interpretative rule regarding the legal authority of the rulemakers. In other instances, it summarizes historical or evidentiary material relevant to the validity and interpretation of the section which precedes it.

(b) *Statutory rules fully incorporated.* Although, for convenience of reference, the statutory basis for this part is set out in full in §§ 2.1 and 2.2, the regulations in Subparts B through E of this part are intended to include all of the operative statutory provisions.

§ 2.6 Administration and enforcement in general.

It is not contemplated that any particular agency will be set up specifically to enforce compliance with this part. Programs which receive Federal grants may be monitored for compliance with this and other applicable Federal law as an incident to the grant administration process. Similarly, FDA inspections of methadone programs will include inspection for compliance with this part, which is incorporated by reference in the methadone regulation (21 CFR 310.505).

§ 2.7 Reports of violations.

Any violation may be reported to the United States Attorney for the judicial district in which the violation occurs. Violations on the part of methadone programs may be reported to the regional offices of the Food and Drug Administration. Violations on the part of a Federal grantee or contractor may be reported to the Federal agency monitoring the grant or contract.

Subpart B—General Provisions

§ 2.11 Definitions and usages.—Rules.

(a) *Authorizing legislation.* The term "authorizing legislation" means section 408 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) and section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582), as such sections may be amended and in effect from time to time.

(b) *Construction of terms.* The definitions and rules of construction set forth in this section are applicable for the purposes of this part. To the extent that they refer to terms used in the authorizing legislation, they are also applicable for the purposes of such legislation.

(c) *Alcohol abuse.* The term "alcohol abuse" includes alcoholism.

(d) *Drug abuse.* The term "drug abuse" includes drug addiction.

(e) *Diagnosis and treatment.* The terms "diagnosis" and "treatment" include interviewing, counselling, and any other services or activities carried on for the purpose of or as an incident to diagnosis, treatment, or rehabilitation with respect to drug abuse or alcohol abuse, whether or not conducted by a member of the medical profession.

(f) *Program.*

(1) The term "program", when referring to an individual or organization, means either an individual or an organization furnishing diagnosis, treatment, or referral for alcohol abuse or drug abuse.

(2) The term "program", when not used in the sense defined in paragraph (f)(1), means a plan or procedure, whether functional or organizational, and whether or not governmental, for dealing with alcohol abuse or drug abuse problems from either an individual or a social standpoint.

(g) *Program evaluation.*

The term "program evaluation" means an evaluation of—

(1) The effectiveness, efficiency, compliance with applicable therapeutic, legal, or other standards, or other aspects of the performance, of a program as defined in paragraph (f)(1) of this section, or

(2) The validity, effectiveness, efficiency, practicability, or other aspects of the utility or success of a program in the sense defined in paragraph (f)(2) of this section.

(h) *Program director.* The term "program director" in the case of a program which is an individual means that individual, and in the case of a program which is an organization, the individual, if any, who is the principal, or, in the case of organizations consisting of partners or under the control of a board of directors, board of trustees or other governing body, the individual designated as program director, managing director, or otherwise vested with executive authority with respect to the organization.

(i) *Patient.* The term "patient" means any individual (whether referred to as a patient, client, or otherwise) who has applied for or been given diagnosis or treatment for drug abuse or alcohol abuse and includes any individual who, after arrest on a criminal charge, is interviewed and/or tested in connection with drug or alcohol abuse preliminary to a determination as to eligibility to participate in a treatment or rehabilitation program.

(j) *Patient identifying information.* The term "patient identifying information" means the name, address, social security number, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a patient identifying number assigned by a program.

(k) *Alcohol abuse or drug abuse prevention function.* The term "alcohol abuse or drug abuse prevention function" means any program or activity relating to alcohol abuse or drug abuse education, training, treatment, rehabilitation, or research, and includes any such function even when performed by an organization whose primary mission is in the field of law enforcement or is unrelated to alcohol or drugs.

(l) The term "person" means an individual, a partnership, a corporation, a trust, a Federal or State governmental agency, or any other legally cognizable entity.

(m) *Service organization.* The term "service organization" means a person which provides services to a program such as data processing, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services.

(n) *Qualified service organization.* The term "qualified service organization" means a service organization which has entered into a written agreement with a program pursuant to which the service organization—

(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the program about patients in the program, it is fully bound by the provisions of this part;

(2) undertakes to institute appropriate procedures for safeguarding such information, with particular reference to patient identifying information; and

(3) undertakes to resist in judicial proceedings any efforts to obtain access to information pertaining to patients otherwise than as expressly provided for in this part.

(o) *Records.* The term "records" includes any information, whether recorded or not, relating to a patient, received or acquired in connection with the performance of any alcohol abuse or drug abuse prevention function, whether such receipt or acquisition is by a program, a qualified service organization, or any other person.

(p) *Communications not constituting disclosure.* The following types of communications do not constitute disclosures of records:

(1) Communications of information within a program between or among personnel having a need for such information in connection with their duties.

(2) Communications between a program and a qualified service organization of information needed by the organization to perform its services to the program.

(3) Communications of information which includes neither patient identifying information nor identifying numbers assigned by the program to patients.

(q) *Previous regulations.* The term "previous regulations" refers to the interpretative regulations issued by the Special Action Office for Drug Abuse Prevention, originally published November 17, 1972, 37 FR 24636, as revised December 6, 1973, 38 FR 33744.

(r) *State law.* The term "State law" refers to the law of a State or other jurisdiction, such as the District of Columbia, as distinguished from Federal law in general. As applied to transactions which do not take place in any State or other similar jurisdiction, the term refers to Federal common law as modified by any applicable Federal statutes and regulations.

(s) *Third party payer.* The term "third party payer" means any organization (or person acting as agent or trustee for an organization or fund) which pays or agrees to pay for diagnosis or treatment furnished or to be furnished to a particular individual, where such payment or agreement to pay is on the basis of an individual relationship between the payer and the patient (or a member of the patient's family in the case of self-and-family insurance coverage or similar arrangements) evidenced by a contract, an insurance policy, a certificate of membership or participation, or similar documentation.

(t) *Funding source.* The term "funding source" means any individual or any public or private organization, including any Federal, State, or local governmental agency, which makes payments in support of a program. A funding source is not, as such, a third party payer, even where its payment sare based directly or indirectly on the program's patient load with or without respect to specified categories of eligible persons.

(u) *August 22, 1974 draft.* References to the "August 22, 1974 draft" are to the draft regulations set out in the Advance Notice of Proposed Joint Rulemaking published in the FEDERAL REGISTER on August 22, 1974, 39 FR 30426, by the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention.

§ 2.11–1 Definitions and usages.—Basis and purpose.

(a) *In general.* The definitions are based upon the legislative history of and experience with the authorizing legislation, and are intended as aids to construing the provisions of this part to carry out the purposes of those statutes.

(b) *Coverage of applicants for treatment.* Section 2.11(i) is intended to make it clear that records of the identity and other information about a person whose application is rejected or withdrawn are fully as much covered by this part as records pertaining to a patient actually accepted for treatment.

(c) *Program terminology for patient not controlling.* While many programs prefer to use "client" or some other term instead of "patient" to describe the recipients of their services, it is believed preferable to use terminology in this part which is consistent with that used in the authorizing legislation. It should be clearly understood, however, that the records of any individual who fits the definition set forth in § 2.11(i) are covered, no matter what terminology the program may use to designate his status.

(d) *Origin of "prevention function" terminology.* The definition of alcohol abuse or drug abuse prevention function in § 2.11(k) is adapted from the definition of drug abuse prevention function in section 103(b) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1103(b)). Although there was no corresponding defined term available to the draftsman of the 1974 amendment to section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582), it is clear from the legislative history that the coverage of alcohol abuse patient records was intended to be fully as wide as the coverage of drug abuse patient records, and the definition in § 2.11(k) reflects that intention.

(e) *Ambiguity of the term "program".* It is recognized that it is ordinarily poor drafting technique to use the same term in senses which are as different, yet related, as those in §§ 2.11(f)(1) and 2.11(f)(2). This part, however, has to be read both in conjunction with the Food and Drug Administration's Methadone Regulation and the Drug Abuse Office and Treatment Act of 1972. The Methadone Regulation (21 CFR 310.505) clearly uses the term "program" in the § 2.11(f)(1) sense. In section 103(b) of the Act (21 U.S.C. 1103(b)), it is clearly used in the § 2.11(f)(2) sense, and the usage in section 408(b)(2)(B) of the Act has from its original enactment been administratively interpreted to include both senses. As used in this part, the context should indicate the intended meanings with sufficient clarity to make this preferable to creating and defining new terminology which would be different from that used in related regulations and the authorizing legislation.

(f) *Construction of disclosures.* Section 2.11(p) is intended to clarify the status of communications which are carried on within a program or between a program and persons or organizations which are assisting it in providing patient care. The authorizing legislation was not intended to prohibit programs from carrying on accepted practices in terms of obtaining specialized services from outside organizations. In conjunction with the definition of qualified service organizations, set forth in § 2.11(n), the provisions of § 2.11(p) should prevent the development of abuses in this area.

§ 2.12 Applicability.—Rules.

(a) *In general.* Except as provided in paragraph (b) of this section, this part applies to records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any alcohol abuse or drug abuse prevention function—

(1) Which is conducted in whole or in part, whether directly or by grant, contract, or otherwise, by any department or agency of the United States,

(2) For the lawful conduct of which in whole or part any license, registration, application, or other authorization is required to be granted or approved by any department or agency of the United States,

(3) Which is assisted by funds supplied by any department or agency of the United States, whether directly through a grant, contract, or otherwise, or indirectly by funds supplied to a State or local government unit through the medium of contracts, grants of any description, general or special revenue sharing, or otherwise, or

(4) Which is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program conducting such function, or by a way of a tax-exempt status for such program.

(b) *Armed Forces and Veterans' Administration.*

(1) The provisions of this part do not apply to any interchange, entirely within the Armed Forces, within those components of the Veterans' Administration furnishing health care to veterans, or between such components and the Armed Forces, of records pertaining to a person relating to a period when such person is or was subject to the Uniform Code of Military Justice.

(2) Except as provided in paragraph (b)(1) of this section, this part applies to any communication between any person outside the Armed Forces and any person within the Armed Forces.

(3) Except as provided in paragraph (b)(1) of this section, this part applies, insofar as it pertains to any drug abuse prevention function, to any communication between any person outside those components of the Veterans' Administration furnishing health care to veterans and any person within such components, until such date as the Secretary of Health, Education and Welfare exercises his authority (conferred by an amendment effective June 30, 1975) to prescribe regulations under section 408 of Pub. L. 92-255 (21 U.S.C. 1175). After such date, this part applies thereto to such extent as the Administrator of Veterans' Affairs, through the Chief Medical Director, by regulation makes the provisions of this part applicable thereto.

(4) Except as provided in paragraph (b)(1) of this section, this part applies, insofar as it pertains to any alcohol abuse prevention function, to any communication between any person outside those components of the Veterans' Administration furnishing health care to veterans and any person within such components, to such extent as the Administrator of Veterans' Affairs, through the Chief Medical Director, by regulation makes the provisions of this part applicable thereto.

(c) *Period covered as affecting applicability.* The provisions of this part apply to records of identity, diagnosis, prognosis, or treatment pertaining to any given individual maintained over any period of time which, irrespective of when it begins, does not end before March 21, 1972, in the case of diagnosis or treatment for drug abuse or before May 14, 1974, in the case of diagnosis or treatment for alcohol abuse.

(d) *Applicability determined by nature and purpose of records.* The applicability of the provisions of this part is determined by the nature and purpose of the records in question, and not by the status or primary functional capacity of the recordkeeper.

§ 2.12-1 Applicability.—Basis and purpose.

(a) The broad coverage provided by § 2.12(a) is appropriate in the light of the remedial purposes of the statutes as well as the practical desirability of certainty and uniformity. Sections 2.12(a)(1) and 2.12(a)(2) simply follow the terms of subsection (a) of the statutes, with some explanatory material for the sake of clarity and explicitness.

(b) Sections 2.12(a)(3) and 2.12(a)(4) are based upon the use by Congress of the phrase "directly or indirectly assisted by any department or agency of the United States". In the light of the multiplicity and extent of Federal programs and policies which can be of assistance to drug and alcoholism programs, this wording strongly suggests an intention to provide the broadest coverage consistent with the literal terms of the statutes. Many programs commence with direct Federal assistance, financial, technical, or both, and later continue with State aid and private, tax-deductible contributions. It would be manifestly contrary to the general policy sought to be effectuated by the legislation if the confidential status of a program's records were to terminate, or even be called into question, by the cessation of direct Federal assistance.

(c) With regard to § 212(a)(3), it seems clear that whenever a State or local government is assisted by the Federal government by way of revenue sharing or other unrestricted grants, all of the programs and activities of the State or local government are thereby indirectly assisted, and thus meet that aspect of the statutory criteria for coverage.

(d) Section 2.12(a)(4) follows the doctrine established in *McGlotten v. Connally*, 338 F. Supp. 448 (D.C. D.C., 1972), in which it was held that the deductible status of contributions to an organization constitutes "Federal financial assistance" within the meaning of section 601 of the 1964 Civil Rights Act (42 U.S.C. 2000d). The inclusion of the adjective "indirect" as a modifier of the term "assistance" as used in the provisions of law authorizing this part suggests an intention to provide coverage at least as broad, if not broader than, section 601 of the Civil Rights Act in respect of financial assistance. See, also, *Green v. Connally*, 330 F. Supp. 1150 (D.C. D.C., 1971) aff'd sub. nom. *Coit v Green*, 404 U.S. 997, 92 S. Ct. 564, 30 L. Ed. 2d 550 (1971).

(e) Section 2.12(b) essentially repeats the interpretation given in § 1401.02(b) of the previous regulation except that it takes account of the special provisions inserted in the new law with reference to the Veterans Administration, and makes clear that the exemption for communications within the military-VA system does not generally apply to records pertaining to civilians.

(f) Section 2.12(c), which deals with the question of how the period covered by any given set of records affects the applicability of these regulations to them, restates the principle set forth in § 1401.02(a) of the previous regulations, and applies it to records in the field of alcohol abuse as well as drug abuse. The authorizing legislation contains no effective date provisions. A construction which would apply the statutes to records of completely closed treatment episodes, records necessarily made and maintained prior to the enactment of the legislation, would create serious administrative problems. It seems doubtful, in any case, whether such records have been "maintained," within the meaning of the statutes, during any period of time after their enactment. On the other hand, if treatment is actually carried on after the enactment of the applicable statute, then all the records should be covered irrespective of when treatment was begun, because such records clearly are being "maintained" after the enactment of the legislation.

(g) Section 2.12(d) has been included to make explicit one of the legal implications of the authorizing legislation, which is cast in terms descriptive of the records which are to be confidential rather than of the recordkeepers on whom a duty is thus imposed. The result is that, for example, where a State agency maintains an individual client record which contains identifying information about a client (i.e., patient) receiving treatment or rehabilitation services for drug abuse, such a record is clearly a record maintained in connection with a drug abuse prevention function, and is subject to the provisions of this part. The fact that the record may also be required by statute or regulations pertaining to eligibility for Federal Financial Participation would in no way exempt the record from the prohibitions and requirements of this part. Thus, it would be unlawful and a violation of these regulations for such a record to be made available to a law enforcement agency, or to determine (without the prior written consent of the client) eligibility for other welfare benefits, or for any other administrative or investigative uses or purposes which would involve or result in an identification of the client to a third party.

§ 2.13 General rules regarding confidentiality.—Rules.

(a) *In general.* Records to which this part applies shall be confidential and may be disclosed only as authorized by this part, and may not otherwise be divulged in any civil, criminal, administrative, or legislative proceeding conducted by any Federal, State, or local authority, whether such proceeding is commenced before or after the effective date of this part.

(b) *Unconditional compliance required.* The prohibition upon unauthorized disclosure applies irrespective of whether the person seeking disclosure already has the information sought, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other justification or basis for disclosure not expressly authorized under this part.

(c) *Information covered by prohibition.* The prohibition on unauthorized disclosure covers all information about patients, including their attendance or absence, physical whereabouts, or status as patients, whether or not recorded, in the possession of program personnel, except as provided in paragraph (d) of this section.

(d) *Crimes on program premises or against program personnel.* Where a patient commits or threatens to commit a crime on the premises of the program or against personnel of the program, nothing in this part shall be construed as prohibiting personnel of the program from seeking the assistance of, or reporting such crime to, a law enforcement agency, but such report shall not identify the suspect as a patient. In any such situation, immediate consideration should be given to seeking an order under Subpart E of this part to permit the disclosure of such limited information about the patient as may be necessary under the circumstances.

(e) *Implicit and negative disclosures prohibited.* The disclosure that a person (whether actual or fictitious) answering to a particular description, name, or other identification is not or has not been attending a program, whether over a period of time or on a particular occasion, is fully as much subject to the prohibitions and conditions of this part as a disclosure that such a person is or has been attending such a program. Any improper or unauthorized request for any disclosure of records or information subject to this part must be met by a noncommittal response.

(f) *In-patients and residents.* The presence of any in-patient in a medical facility or resident in a residential facility for the treatment of drug or alcohol abuse may be acknowledged to callers and visitors with his written consent. Without such consent, the presence of any in-patient or resident in a facility for the treatment of a variety of conditions may be acknowledged if done in such a way as not to indicate that the patient is being treated for drug or alcohol abuse.

§ 2.13–1 General rules regarding confidentiality.—Basis and purpose.

(a) Section 2.13(a) enunciates the general principle of the statutory provisions, and is unchanged from § 1401.03 of the previous regulations.

(b) Sections 2.13(b) and 2.13(c) have been added on the basis of written comments on the draft regulations published August 22, 1974, in which there was a documented report that counsel for a program had advised the program that it could furnish information to the FBI about patients without their written consent and without completing a full judicial proceeding in accordance with Subpart E of this part. Sections 2.13(b) and 2.13(c) should clarify the original intent of the statutes and regulations to the extent of precluding such errors in the future.

(c) In the situation described in § 2.13(d), the desirability of the general prophylactic rule prohibiting disclosures by program personnel about patients regardless of whether such disclosures are from a written record must yield to the practical necessity to permit protection from, and prompt reporting of, criminal acts. In the preface to the first set of regulations issued under 21 U.S.C. 1175, it was emphasized that the operation of that section "in no way creates a sanctuary for criminals." (37 FR 24636, November 17, 1972). Section 2.13(d) is consistent with that contemporaneous administrative construction.

(d) Section 2.13(e) is adapted from § 1401.11 of the August 22, 1974 draft. The suggestion that this part be cited when declining to give information has been deleted on the basis of comments that correctly pointed out that such a citation, if given by an institution or program maintaining some records covered by this part and some not, would serve to identify the records inquired about as pertaining to treatment covered by this part.

Section 2.13(f) merely clarifies the effect of the preceding paragraphs in the special situations to which paragraph (f) relates.

§ 2.14 Penalty for violations.—Rules.

(a) *Penalty provided by law.* Any person who violates any provision of the authorizing legislation or any provision of this part shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(b) *Application to subsequent offenses.* Where a defendant has committed one offense under either section authorizing this part or any provision of this part authorized by that section, any offense thereafter committed under the same section or any provision of this part authorized under that section shall be treated as a subsequent offense.

§ 2.14–1 Penalty for violations.—Basis and purpose.

(a) Section 2.14 states the criminal penalty provided for in subsection (f) of the sections authorizing this part. It is included in this part for convenience and completeness. Some of the comments received on this section when originally proposed suggested that criminal penalties for violation should include imprisonment, but such a change would have to be made by legislation rather than rulemaking.

(b) Section 2.14(b) clarifies the intention that the "subsequent offense" need not be identical to the first offense, as long as it is committed with respect to the same statutory section. For example, a person whose first offense had consisted of improperly releasing the name of a patient in an alcoholism treatment program would be punishable for a "subsequent offense" if he later gives out information from the diagnostic work-up of an alcoholism patient.

§ 2.15 Minor patients.—Rules.

(a) *Definition of minor.* The term "minor" means a person who has not attained the age of 18 years or, in a State where a different age is expressly provided by State law as the age at which a person ceases to be a minor, the age prescribed by the law of such State.

(b) *Consent to disclosure in general.* Except as provided in paragraph (c), where consent is required for any disclosure under this part, such consent in the case of a minor must be given by both the minor and his parent, guardian, or other person authorized under State law to act in his behalf, but any disclosure made after the patient has ceased to be a minor may be consented to only by the patient.

(c) *Rule when State law authorizes treatment without parental consent.* Whenever a patient, acting alone, has the legal capacity under the applicable State law to apply for and obtain such diagnosis, counselling, administration of medication, or other services as actually are or were provided to him by the program with respect to which he is or was a patient, any consent required for disclosure under this part may be given only by the patient, notwithstanding the fact that the patient may be a minor.

(d) *Initial contacts.* When a minor applies for services under circumstances other than those described in paragraph (c) of this section, the fact of such application may not be disclosed, except as an incident to a communication authorized under paragraph (f) of this section, without consent of the applicant, to the applicant's parent, guardian, or other person authorized under State law to act on behalf of the applicant. When such an applicant refuses consent, it must be explained to the applicant that while he or she has the right (subject to the provisions of paragraph (f) of this section) to withhold such consent, the services applied for cannot be provided without it.

(e) *Collection or attempted collection of payment for services.* Where State law authorizes the furnishing of services to a minor without the consent of the minor's parent or guardian, no inquiry may be made of the parent's or guardian's financial responsibility, and no bill, statement, request for payment, or any other communication in respect of such services may be transmitted directly or indirectly to such parent or guardian, without the express written consent of the patient. Such consent may not be made a condition of the furnishing of services except in the case of a program which is not required by law, and does not in fact hold itself out as willing, to furnish services irrespective of ability to pay.

(f) *Applicant lacking capacity for rational choice.* When, in the judgment of a program director a minor applicant for services, because of extreme youth or mental or physical condition, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, and the situation of the applicant poses a substantial threat to the life or physical well being of the applicant or any other individual, and such threat might be reduced by communicating the relevant facts to a parent or guardian of the applicant, such facts may be so communicated by the program director or by program personnel authorized by the director to do so.

§ 2.15–1 Minor patients.—Basis and purpose.

(a) The statutes authorizing this part are totally silent on the issue of the capacity of a minor to give consent for disclosures, and there is nothing in the legislative history to suggest that the question was ever considered by Congress. The question is, however, one which arises repeatedly, and it is therefore appropriately addressed under the general rulemaking authority conferred by subsection (g) of the authorizing legislation.

(b) Perhaps no legal issues are more highly charged than those affecting the relationship of parent and child. Since Congress has not evidenced an intention to affect this relationship, it is clear that local law should govern, and the task of rulemaking is limited to that of insuring, as far as possible, that the results under Federal law are consistent with local policy.

(c) Where a State has authorized the furnishing of treatment or other services of a given type to a minor without notice to or consent by the parent or guardian, it seems clear that a consistent Federal policy with respect to disclosure requires that consent for any disclosure of the treatment record be given by the minor. This policy, moreover, should not be frustrated by attempts to enforce parental financial responsibility in a situation where the State itself has determined that the minor should have a right to obtain services without involving the parent.

(d) A much more difficult problem is presented in the case of a minor who applies for services in a jurisdiction which has not determined that a minor should have the right to obtain them without parental knowledge or consent. The question may arise as to whether the clinician has an ethical or legal duty to notify the parent which conflicts with a duty of nondisclosure. The rules in § 2.15 are based upon the theory that Federal law should not invalidate a State policy which prohibits treatment without parental consent, but that keeping confidential a mere application for treatment is not ordinarily a sufficient transgression of such a State policy as to require an exception to the general Federal policy prohibiting disclosure of an application for services without the consent of the applicant.

(e) Section 2.15(f) deals with the case of the minor applicant who lacks the capacity to make a rational choice about consenting to disclosure. It is based upon the theory that where a person is actually as well as legally incapable of acting in his own interest, disclosures to a person who is legally responsible for him may be made to the extent that the best interests of the patient clearly so require. Any other rule could subject clinicians to an intolerable choice between violating the provisions of this part on the one hand, or failing to take action to avoid a preventable tragedy involving a minor, on the other. The statutes authorizing this part should not be read as requiring such a choice.

§ 2.16 Incompetent and deceased patients.—Rules.

(a) *Incompetent patients other than minors.* Where consent is required for any disclosure under this part, such consent in the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(b) *Deceased patients.*

(1) *In general.* Except as provided in paragraph (b)(2) of this section, where consent is required for any disclosure of this part, such consent in the case of records of a deceased patient may be given by an executor, administrator, or other personal representative. If there is no appointment of a personal representative, such consent may be given by the patient's spouse, or if none, by any responsible member of the patient's family.

(2) *Vital statistics.* In the case of a deceased patient, disclosures required under Federal or State laws involving the collection of death and other vital statistics may be made without consent.

§ 2.16–1 Incompetent and deceased patients.—Basis and purpose.

Section 2.16 essentially repeats the substance of § 1401.04 of the previous regulations, broadened to reflect the fact that the statutes now allow any consensual disclosures permitted by the regulations, and to cover the situation of deceased patients for whom no formal appointment of an executor, administrator, or other personal representative has been made. Written comments were received to the effect that the power to consent to disclosure in the case of a deceased patient should be limited to a personal representative. The expense of probate or administration in some jurisdictions could cause financial hardship to survivors, and on balance it is believed that where the assets of an estate are insufficient to justify the appointment of a personal representative, the public interest is served by permitting others to consent to disclosure.

§ 2.17 Security precautions.—Rules.

(a) *Precautions required.* Appropriate precautions must be taken for the security of records to which this part applies. Records containing any information pertaining to patients shall be kept in a secure room, or in a locked file cabinet, safe, or other similar container, when not in use.

(b) *Policies and procedures.* Depending upon the type and size of the program, appropriate policies and procedures should be instituted for the further security of records. For example, except where this function is personally performed by the program director, a single member of the program staff should be designated to process inquiries and requests for patient information, and a written procedure should be in effect regulating and controlling access by those members of the staff whose responsibilities require such access, and providing for accountability.

§ 2.17–1 Security precautions.—Basis and purpose.

The enormous variations in both the size and the type of programs to which this part is applicable preclude the formulation of specific requirements with respect to the physical security of records. Almost any requirement which could be laid down would, under some circumstances, either be impracticable or perverse in its effects. For example, in a facility handling a variety of medical records, all of which are confidential and so marked, a requirement that those pertaining to drug or alcohol treatment be marked in any distinctive way would merely serve to identify such records as pertaining to drug or alcohol treatment—precisely the opposite of the intended result. The purpose of § 2.17, which is based upon § 1401.25 of the previous regulations, is to alert programs to the necessity of exercising due care with respect to the security of patient records.

§ 2.18 Extent of disclosure.—Rule.

Any disclosure made under this part, whether with or without the patient's consent, shall be limited to information necessary in the light of the need or purpose for the disclosure.

§ 2.18–1 Extent of disclosure.—Basis and purpose.

(a) Section 2.18 expresses the general principle, which has application in many different contexts, that any disclosure from records covered by this part should be limited to information necessary in the light of the need or purpose for the disclosure. It is identical to § 1401.06 of the previous regulations.

(b) This section should not be misunderstood as imposing a limitation on the scope of records which may or should be made available to health agencies conducting inspections as described in § 2.55. All of the records maintained by a program may be relevant to such inspection. The Congress has determined that disclosure under such circumstances is not a violation of the statutes authorizing this part; where such disclosure is required by Federal or State law, and the inspecting agency is a qualified State health agency as defined in § 2.55(e)(1), it becomes the responsibility of that agency to protect the confidentiality of information it acquires in the course of its lawful activities.

§ 2.19 Undercover agents and informants.—Rules.

(a) *Definitions.* As used in this section, § 2.19–1, and §§ 2.67 and 2.67–1,—

(1) The term "undercover agent" means a member of any Federal, State, or local law enforcement or investigative agency whose identity as such is concealed from either the patients or personnel of a program in which he enrolls or attempts to enroll.

(2) The term "informant" means a person who, at the request of a Federal, State, or local law enforcement or investigative agency or officer, carries on observation of one or more persons enrolled in or employed by a program in which he is enrolled or employed, for the purpose of reporting to such agency or officer information concerning such persons which he obtains as a result of such observation subsequent to such request.

(b) *General prohibition.* Except as otherwise provided in paragraph (c) of this section, or as specifically authorized by a court order granted under § 2.67,—

(1) No undercover agent or informant may be employed by or enrolled in any alcohol or drug abuse treatment program;

(2) No supervisor or other person having authority over an undercover agent may knowingly permit such agent to be or remain employed by or enrolled in any such program; and

(3) No law enforcement or investigative officer may recruit or retain an informant with respect to such a program.

(c) *Exceptions.* The enrollment of a law enforcement officer in a treatment program shall not be deemed a violation of this section if (1) such enrollment is solely for the purpose of enabling the officer to obtain treatment for his own abuse of alcohol or drugs, and (2) his status as a law enforcement officer is known to the program director.

§ 2.19–1 Undercover agents and informants.—Basis and purpose.

(a) In many instances, persons who are patients in treatment programs are making their first tentative efforts toward re-integration into productive society. They may be both vulnerable and suspicious, and the presence in a treatment program of undercover law enforcement agents or informants can have a devastating effect on the program's morale and therapeutic effectiveness. Moreover, it would appear that the purpose of such agents or informants may be to obtain precisely the type of personal information which might be revealed by inspection of counselor notes and other patient records maintained by the program. Thus, the placing of an undercover agent or informant in a program, either as a patient or as an employee, would appear to be contrary to the purposes for which the provisions of law authorizing this part were enacted, and properly subject to prohibition under regulations expressly authorized to carry out those purposes.

(b) From a policy standpoint, § 2.19 is based on the reasoning that while the use of undercover agents and informants in treatment programs is ordinarily to be avoided, there may occasionally arise circumstances where their use may be justified. Accordingly, where a showing is made in an application for an order under § 2.67 that the criteria set forth in that section are satisfied, the court may grant such an order.

(c) When this section of the regulations was proposed, numerous written comments were received urging that there be an absolute prohibition on the use of undercover agents and informants, and most of the witnesses at the hearings who addressed the issue at all testified to the same effect. A number of comments were received to the effect that § 2.19 should be dropped altogether, but this request was always clearly and often explicitly predicated on the assumption that failure to say anything about undercover agents and informants would make their use illegal. Our view is to the contrary: we think that the statutes, standing alone, do not prohibit the practice, and thus that in the absence of a specific prohibition in these regulations, the use of undercover agents and informants in treatment programs would not be unlawful. Since this is a view which we believe to be shared by the law enforcement and investigative agencies which are affected by § 2.19, there is as a practical matter no alternative to predicating these regulations upon its correctness.

(d) However desirable it may be to limit the use of undercover agents and informants in treatment programs, we think a strong argument can be made against our power to impose an absolute prohibition. To the extent that the practice is susceptible to regulation through the rulemaking process at all, it is on the theory that it opens the way to disclosure of information which is or should be in program records, and thus is contrary to the purposes of the statutes. Since subsection (g) of the statutes confers express rulemaking authority to carry out these purposes, regulation of the use of undercover agents and informants is a proper subject for the exercise of that authority. But even the express statutory prohibition against direct disclosure of the content of patient records is subject to the power of the courts to authorize such disclosure under subsection (b)(2)(C) of the statutes. It seems difficult to argue that Congress intended to confer on rulemaking agencies the authority to impose an absolute prohibition even though its own restrictions (other than those on disclosures of patient identities from secondary records) are subject to being set aside by court order in particular cases. Since we have not attempted to exercise such an authority, it is not necessary to decide at this time whether it was conferred

(e) A careful reading of the definitions set forth in § 2.19(a) is crucial to an understanding of the prohibitions which are imposed by § 2.19. Objections to the section were made informally but vigorously on behalf of the Drug Enforcement Administration, on the ground that the testimony of informants or undercover agents is frequently if not normally essential to the successful prosecution of cases arising under the Controlled Substances Act. It was said that in the form originally proposed, the section would cut off from treatment those who might agree to cooperate with law enforcement authorities, a result both inhumane and counterproductive. As the definition of an informant is intended to make clear, however, it is his function vis-a-vis personnel and fellow patients in the program in which he is enrolled which is controlling, and not his relationship, *per se*, with an investigative agency.

(f) Finally, the definition of informant is intended to clarify the distinction between an informant and an ordinary witness. It is the element of prearrangement which is crucial. In one of the comments received on §2.19 as proposed, it was urged that treatment programs should be considered as sanctuaries, but such a result was explicitly disclaimed in the initial publication of the previous regulations (37 FR 24636). In so saying, we are by no means insensitive to the anxieties repeatedly expressed in both testimony and comments on this section, but we believe that the prohibition contained in § 2.19 and the procedures and criteria set forth in § 2.67 provide a measure of relief which is consistent with the structure and intent of the underlying statutes.

§ 2.20 Identification cards.—Rules.

(a) *Required use prohibited.* No program may require or request any patient to carry in his or her possession, while away from the program premises, an identification card or other form of identification which is issued by the program or which would tend to identify the bearer as a participant in it or any similar program.

(b) *Conditions of voluntary use.* Nothing in this section prohibits a program from issuing an identification card to a patient if the patient's counsellor or other authorized member of the program staff has explained to the patient that acceptance and use of the card is entirely voluntary and that neither an initial rejection nor a subsequent discontinuation of its use will in any way prejudice his or her record or standing in the program. In the case of any patient to whom an identification card or similar device was issued prior to the effective date of this section, or subsequent thereto in violation of this section, a counsellor or other authorized member of the program staff shall explain to the patient his right to turn it in without prejudice at any time.

(c) *On-premises exemption.* Nothing in this section prohibits a program from maintaining and using on its premises cards, photographs, tickets, or other devices, or using passwords or other information, to assure positive identification of patients, correct recording of attendance or medication, or for other proper purposes, as long as no pressure is brought on any patient to carry any such device when away from the program premises.

§ 2.20–1 Identification cards.—Basis and purpose.

Section 2.20 is in furtherance of one of the basic purposes of the statutes authorizing this part, namely, protection of patients from improper disclosure of their status as such. Regrettably there appear to be areas where possession of a treatment program identification card can be prejudicial to a person under arrest or subjected to a search. In any part of the country, the accidental display or circulation of such a card by reason of its loss or theft could have adverse consequences for a variety of reasons. Since programs have other means of achieving the ends which identification cards are meant to serve, patients who do not wish to assume whatever risks may be involved in carrying such cards should not be compelled to do so.

§ 2.21 Disposition of discontinued program records.—Rules.

(a) *General rule.* When a program discontinues operations or is taken over or acquired by another program, its records to which this part applies with respect to any patient may, with the written consent of that patient, be turned over to the acquiring program or, if none, to any other program specified in the patient's consent. Except as otherwise provided in this section, any records to which this part applies, but for the transfer of which patient consent is not obtained, shall be either completely purged of patient identifying information, or destroyed. If any effort to obtain consent for transfer is made, it shall be by means which minimize the likelihood of accidental or incidental disclosure to any third party of the patient's identity as such.

(b) *Retention period.* Where records are required by law to be kept for a specified period, and such period does not expire until after the discontinuation or acquisition of the program, and patient consent for their transfer is not obtained, such records shall be sealed in envelopes or other containers marked or labelled as follows: "Records of [insert name of program] required to be maintained pursuant to [insert citation to law or regulation requiring that records be kept] until a date not later than December 31, [insert appropriate year]." The same procedure may be followed when it is determined to retain records for the period of any applicable statute of limitations.

(c) *Custodial retention.* Records marked and sealed in accordance with paragraph (b) of this section may be held by any lawful custodian, but may be disclosed by such custodian only under such circumstances and to such extent as would be permissible for the program in which they originated. As soon as practicable after the date specified on the label or legend required to be affixed pursuant to paragraph (b) of this section, the custodian shall destroy the records. In the case of any program terminated by reason of bankruptcy, the expense of compliance with this paragraph shall be an expense of administration of the bankrupt estate.

§ 2.21–1 Disposition of discontinued program records.—Basis and purpose.

While arguments can be made for requiring the destruction of records at the conclusion of their useful clinical life, there is wide disagreement on its span, and there are in addition research considerations which argue for an even longer period of retention. Except in the case of discontinued programs, it therefore seems best to leave this issue for determination by the programs concerned.

§ 2.22 Former employees and others.—Rules.

The prohibitions of this part on disclosure of patient records or information contained therein apply to all individuals who are personnel of treatment programs, researchers, auditors, evaluators, service organizations, or others having access to such records or information, and continue to apply to such individuals with respect to such records or information after the termination of their employment or other relationship or activity giving rise to such access.

§ 2.22–1 Former employees and others.—Basis and purpose.

The probition contained in § 2.22 is arguably an interpretation of the authorizing legislation which would be necessary as a matter of law even in the absence of this part; its validity as an exercise of the rulemaking power conferred by subsection (g) of the authorizing legislation seems beyond dispute.

§ 2.23 Relationship to State laws.—Rules.

The enactment of the provisions of law authorizing this part was not intended to preempt the field of law covered thereby to the exclusion of State laws not in conflict therewith. If a disclosure permitted under the provisions of this part, or under a court order issued pursuant thereto, is prohibited under State law, nothing in this part or in the provisions of law authorizing this part may be construed to authorize any violation of such State law. No State law, however, may either authorize or compel any disclosure prohibited by this part.

§ 2.23–1 Relationship to State laws.—Basis and purpose.

Section 2.23 sets forth publicly an interpretation which, in informal communications, has consistently been given to 21 U.S.C. 1175 since its original enactment, and clearly has equal applicability to 42 U.S.C. 4582.

§ 2.24 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act.—Rules.

(a) *Research privilege description.* In some instances, there may be concurrent coverage of a program or activity by the provisions of this part and by a regulation or other administrative action under section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c)). The latter two provisions of law, referred to hereinafter in this section as the research privilege sections, confer on the Secretary of Health, Education, and Welfare, and on the Attorney General, respectively, the power to authorize researchers to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subject of such research. The Secretary of Health, Education, and Welfare may grant this privilege with respect to any "research on mental health, including research on the use and effect of alcohol and other psychoactive drugs." The Attorney General's power is conferred as part of a section authorizing research related to enforcement of laws under his jurisdiction concerning substances which are or may be subject to control under the Controlled Substances Act, but is not expressly limited to such research. Regardless of whether a grant of research privilege is made by the Secretary or by the Attorney General, it is expressly provided that persons who obtain it "may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding to identify" the subjects of research for which the privilege was obtained.

(b) *Comparison with authority for this part.* Although they deal, in a sense, with the same subject matter, and may on occasion concurrently cover the same transactions, it is important to note the differences between the research privilege sections (21 U.S.C. 872(c) and 42 U.S.C. 242a(a)) and the provisions of law (21 U.S.C. 1175 and 42 U.S.C. 4582) which authorize this part. Briefly, these differences are as follows:

(1) Although they contain broad grants of express rulemaking authority, the provisions of law by which this part is authorized are self-executing in the sense that they are operative irrespective of whether the rulemaking authority is exercised. The protection afforded by the research privilege sections, on the other hand, can only come into existence as a result of affirmative administrative action.

(2) The provisions of law authorizing this part, as well as the provisions of this part itself, impose affirmative duties with respect to the records to which they apply, and the violation of such duties is subject to criminal penalties. To the extent that a privilege is thereby created, it grows out of the duties thus imposed. The research privilege sections, by contrast, impose no duties by their own terms, and if any duties are implied from their existence, they would have to be enforced on the basis of an implicit civil liability for damages or by equitable relief, as there are no criminal or administrative sanctions available.

(3) The exercise of the authority conferred by the research privilege sections is subject to administrative discretion, whereas in the case of the duties imposed under this part there is judicial discretion, within the limits and subject to procedures and criteria prescribed by statute and regulation, to grant relief in particular cases.

(c) *Grant of research privilege not affected by (b)(2)(C) order.* The issuance of an order under subsection (b)(2)(C) of either of the sections authorizing this part (21 U.S.C. 1175 and 42 U.S.C. 4582) in no way affects the continuing effectiveness of any exercise of the authority of the Secretary of Health, Education, and Welfare under 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) or the Attorney General under section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c)).

§ 2.24–1 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act.—Basis and purpose.

(a) In Pub. L. 93–282, the Congress expressly amended (by sections 122(a) and 303(a), 88 Stat. 131 and 137) the provisions of law which authorize this part, expressly amended (by section 122 (b), 88 Stat. 132) the research privilege section under the Secretary's jurisdiction, and made explicit reference (in section 303(d), 88 Stat. 139) to the regulations previously issued by the Special Action Office for Drug Abuse Prevention reconciling the provisions of section 408 of the Drug Abuse Office and Treatment Act of 1972 with the provisions of the research privilege sections. When the bill which became Pub. L. 93–282 was before the House of Representatives for its last Congressional consideration before transmission to the President, its floor manager, Chairman Staggers of the Committee on Interstate and Foreign Commerce, inserted in the Record a detailed analysis of the bill in its final form (Congressional Record, daily edition, May 6, 1974, page H3563). This analysis contained the following paragraph:

> The relationship of section 303(a) of the Public Health Service Act, authorizing the administrative grant of absolute confidentiality for research, to section 408 of the Drug Abuse Office and Treatment Act of 1972, requiring that Federally-connected drug abuse patient records generally be kept confidential, has been correctly described in an interpretative regulation, 21 C.F.R. 1401.61 and 1401.62, which was upheld in *People v. Newman*, 32 N.Y. 2d 379, [reversing] 336 N.Y.S. 2d 127, 298 N.E. 2d 651 (1973); *certiorari* denied, [414] U.S. [1163], 94 S. Ct. 927, [39 L. Ed. 2d 116] (1974). For that reason, among others, section 303(d) of the Senate amendment expressly continues the effectiveness of the current regulation promulgated by the Director of the Special Action Office for Drug Abuse Prevention. Thus, although section 502(c) of the Comprehensive Drug Abuse Prevention and Control Act of 1970 is not explicitly referred to in this legislation, the congressional intent is clear that the authority conferred by that section was not modified by Pub. L. 92–255, and is not intended to be modified by the bill now before the House.

(b) Sections 2.24 and 2.61 restate, in substance, the interpretative rules (§§ 1401.61 and 1401.62 of the previous regulations) referred to in the passage quoted in paragraph (a) of this section, modified to reflect the amendment made to section 303(a) of the Public Health Service Act (42 U.S.C. 242(a)) by Pub. L. 93–282.

Subpart C—Disclosures With Patient's Consent

§ 2.31 Written consent required.—Rules.

(a) *Form of consent.* Except as otherwise provided, a consent for a disclosure under this part must be in writing and must contain the following:

(1) The name of the program which is to make the disclosure.

(2) The name or title of the person or organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose or need for the disclosure.

(5) The extent or nature of information to be disclosed.

(6) A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and a specification of the date, event, or condition upon which it will expire without express revocation.

(7) The date on which the consent is signed.

(8) The signature of the patient and, when required under § 2.15, the signature of a person authorized to give consent under that section; or, when required under § 2.16, the signature of a person authorized to sign under that section in lieu of the patient.

(b) *Duration of consent.* Any consent given under this subpart shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

(c) *Disclosure prohibited with deficient consent.* No program may disclose any information on the basis of a consent form—

(1) which on its face substantially fails to conform to any of the requirements set forth in paragraph (a), of this section, or

(2) which is known, or in the exercise of reasonable care should be known, to the responsible personnel of the program to be materially false in respect to any item required to be contained therein pursuant to paragraph (a) of this section.

(d) *Falsification prohibited.* No person may knowingly make, sign, or furnish to a program any consent form which is materially false with respect to any item required to be contained therein pursuant to paragraph (a) of this section.

§ 2.31–1 Written consent required.—Basis and purpose.

(a) The use of a consent form containing all of the elements specified in § 2.31(a) is necessary to assure compliance with the requirements of this subpart. Under § 1401.21 of the previous regulations, a much more abbreviated form was permissible, because the circumstances under which any consent could be given were very strictly limited. Now that the authorizing legislation permits disclosure with consent "to such extent, under such circumstances, and for such purposes as may be allowed under regulations," the consent form should show on its face information sufficient to indicate compliance with the regulations.

(b) Sections 2.31(b), 2.31(c), and 2.31 (d) are an exercise of the general rulemaking authority in subsection (g) of the authorizing legislation. Section 2.31 (c) imposes a legal liability on programs and their personnel for disclosure of information on the basis of a materially deficient consent, and § 2.31(d) imposes liability on any person who submits a falsified consent form to a program.

§ 2.32 Prohibition on redisclosure.—Rules.

(a) *Notice to accompany disclosure.* Whenever a written disclosure is made under authority of this subpart, except a disclosure to a program or other person whose records pertaining to the patient are otherwise subject to this part, the disclosure shall be accompanied by a written statement substantially as follows: "This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose." An oral disclosure may be accompanied or followed by such a notice.

(b) *Consent required for redisclosure.* A person who receives information from patient records and has been notified substantially in accordance with paragraph (a) of this section is prohibited from making any disclosure of such information except with the specific written consent of the person to whom it pertains, or as otherwise permitted under this part.

(c) *Restriction on redisclosure.* Whenever information from patient records is needed by any person, such information must be obtained directly from the program maintaining such records and not from another person to whom disclosure thereof has been made, except where the initial disclosure was intentionally and expressly made for the purpose of redisclosure (as for example in the case of an employment agency), or the information is no longer available from the program and redisclosure is not prohibited by any other provision of this part.

§ 2.32-1 Prohibition on redisclosure.—Basis and purpose.

(a) Section 2.32 is intended to provide a reasonable protection against redisclosure of information disclosed with consent in accordance with this subpart. There is, of course, no problem where the information becomes part of a record which is itself subject to this part because it is maintained in connection with the performance of a covered substance abuse prevention function. The difficulty arises when the disclosure is made to those whose records are not otherwise affected by this part. To attempt to make all of the provisions of this part applicable to such recipients with respect to such information might raise serious problems of legality, administrative feasibility, and fairness, but where they are given actual notice that specific patient consent is normally required for redisclosure, we think they can and should be bound by it.

(b) Oral disclosures are not mandatorily covered because they should rarely be made to any recipient with whom the program does not have a continuing relationship. Where such a relationship exists or the program is otherwise satisfied that the recipient understands and will respect the confidential nature of the information supplied, there seems no need to add to the already heavy load of paperwork with which programs must contend.

§ 2.33 Diagnosis, treatment, and rehabilitation.—Rules.

(a) *Disclosure authorized.* Where consent is given in accordance with § 2.31, disclosure of information subject to this part may be made to medical personnel or to treatment or rehabilitation programs where such disclosure is needed in order to better enable them to furnish services to the patient to whom the information pertains.

(b) *Traveling, incarcerated, or hospitalized patients on medication.* Where a patent on medication is at a distance from his normal residence or treatment program or is incarcerated or hospitalized, or is otherwise unable to deliver a written consent to his treatment program at the time the disclosure is needed, confirmation of the patient's status and information necessary to appropriately continue or modify his medication may be given to medical personnel in a position to provide services to the patient upon the oral representation of such personnel that the patient has requested medication and consented to such disclosure. Any program making a disclosure in accordance with this paragraph shall make a written memorandum showing the name of the patient, or the patient's case number assigned by the program, the date and time the disclosure was made, the information disclosed, and the names of the individuals by whom and to whom it was made.

§ 2.33-1 Diagnosis, treatment, and rehabilitation.—Basis and purpose.

(a) Section 2.33(a) is a restatement of the policy set forth in § 1401.22(a) of the previous regulations, expanded to make explicit reference to nonmedical counselling and other treatment and rehabilitative services.

(b) Section 2.33(b) clarifies the corresponding provision in § 1401.22(a) of the previous regulations by specifying how and through whom oral consent can be given, and limiting the disclosure to that necessary to determine appropriate medication.

§ 2.34 Prevention of certain multiple enrollments.—Rules.

(a) *Definitions.* For the purposes of this section and § 2.55—

(1) The terms "administer", "controlled substance", "dispense", "maintenance treatment", and "detoxification treatment" shall respectively have the meanings defined in paragraphs (2), (6), (10), (27), and (28) of section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) The term "program" means a program which offers maintenance treatment or detoxification treatment.

(3) The term "permissible central registry" means a qualified service organization which collects or accepts, from two or more programs (referred to hereinafter as member programs) all of which are located either within a given State or not more than 125 miles from the nearest point on the border of such State, patient identifying information about persons applying for maintenance treatment or detoxification treatment for the purpose of enabling the member programs to prevent any individual from being concurrently enrolled in more than one such program.

(b) *Use of central registries prohibited except as expressly authorized.* The furnishing of patient identifying information by a program to any central registry which fails to meet the definition of a permissible central registry set forth in paragraph (a)(3) of this section is prohibited, and the furnishing of patient identifying information to or by any central registry except as authorized in this section is prohibited. Information pertaining to patients held by a central registry may be furnished or used in accordance with paragraphs (e), (f), and (g) for the purpose of preventing multiple enrollments, but may not be otherwise furnished or used in connection with any legal, administrative, supervisory, or other action with respect to any patient.

(c) *Safeguards and procedures required.* To minimize the likelihood of disclosures of information to impostors or others seeking to bring about unauthorized or improper disclosure, any communications carried on by programs pursuant to this section must be conducted (1) by authorized personnel designated in accordance with § 2.17(b), and (2) in conformity with procedures established in accordance with that section.

(d) *Disclosures with respect to patients in treatment.* A member program may supply patient identifying information and information concerning the type of drug used or to be used in treatment and the dosage thereof, with relevant dates, to a permissible central registry with respect to any patient—

(1) When the patient is accepted for treatment,

(2) When the type or dosage of the drug is changed, and

(3) When the treatment is interrupted, resumed, or terminated.

(e) *Disclosures with respect to applications.* When any person applies to a program for maintenance treatment or detoxification treatment, then for the purpose of inquiring whether such person is currently enrolled in another program for such treatment, the program may furnish patient identifying information with respect to such person—

(1) To any permissible central registry of which the program is a member, and

(2) To any other program which is not more than 200 miles distant and which is not a member of any central registry of which the inquiring program is a member.

(f) *Program procedure in case of apparent concurrent enrollment.* When an inquiry pursuant to paragraph (e)(2) is made of another treatment program and its response is affirmative, the two programs may engage in such further communication as may be necessary to establish whether an error has been made, and if none, the programs should proceed in accordance with sound clinical practice and any applicable regulations pertaining to the type of treatment involved.

(g) *Registry procedure in case of apparent concurrent enrollment.* When an inquiry pursuant to paragraph (e)(1) is made of a permissible central registry and its response is affirmative, it may advise the inquiring program of the name, address, and telephone number of the other program, or it may advise the other program of the identity of the patient and the name, address, and telephone number of the inquiring program, or it may do both, and in any case the two programs may then communicate as provided in paragraph (f) above.

(h) *Advice to patients.* When the policies and procedures of any program involve any disclosures pursuant to this section, before any patient is accepted for or continued in treatment (other than detoxification treatment) after September 30, 1975, written consent in accordance with § 2.31 shall be obtained. Such consent shall set forth a current list of the names and addresses either of any programs or of any central registries to which such disclosures will be made. Notwithstanding the requirement of § 2.31 (a)(2), such consent shall be effective with respect to any other such program thereafter established within 200 miles, or any registry serving such programs, and shall so state. Such consent shall be effective for as long as the patient remains enrolled in the program to which it is given.

§ 2.34–1 Prevention of certain multiple enrollments.—Basis and purpose.

Section 2.34 is based upon § 1401.43 of the previous regulations. It was omitted from the August 22, 1974 draft, but comments on the omission made it clear that in certain areas of the country, central registries are a functional component of the treatment system, and that regulations to guide their operations are needed.

§ 2.35 Legal counsel for patient.—Rules.

When a bona fide attorney-client relationship exists between an attorney-at-law and a patient, disclosure of any information in the patient's records may be made to the attorney upon the written application of the patient endorsed by the attorney. Information so disclosed may not be further disclosed by the attorney.

§ 2.35–1 Legal counsel for patient.—Basis and purpose.

Section 2.35 simplifies and broadens the statement of the policy embodied in § 1401.25 of the previous regulations. Its purpose is to assure the availability to the attorney, with his client's consent, of any information needed as a basis for advice and counsel. The purpose of the prohibition on further disclosure by the attorney is to guard against the possibility that the attorney might be forced to serve as a conduit for otherwise prohibited disclosures to third parties. Ordinarily, the attorney-client privilege would suffice, but that privilege is subject to waiver by the client, whereas this prohibition is not. Where there is a need for disclosure to a third party of any given information about any patient, this prohibition in no way affects the availability of other sections of this part to authorize such disclosure by the program.

§ 2.36 Patient's family and others.—Rule.

Where consent is given in accordance with § 2.31, information evaluating his current or past status in a treatment program may be furnished to any person with whom the patient has a personal relationship unless, in the judgment of the person responsible for the patient's treatment, the disclosure of such information would be harmful to the patient.

§ 2.36–1 Patient's family and others.—Basis and purpose.

Section 2.36 expresses the same policy as was embodied in § 1401.27 of the previous regulations, broadened to reflect the expanded authority for consensual disclosure under the authorizing legislation.

§ 2.37 Third-party payers and funding sources.—Rules.

(a) *Acquisition of information.* Disclosure of patient information to third-party payers or funding sources may be made only with the written consent of the patient given in accordance with § 2.31 and any such disclosure must be limited to that information which is reasonably necessary for the discharge of the legal or contractual obligations of the third-party payer or funding source.

(b) *Prohibition on disclosure.* Where a funding source or third-party payer maintains records of the identity of recipients of treatment or rehabilitation services for alcohol or drug abuse such records are, under the authorizing legislation, maintained in connection with the performance of an alcohol or drug abuse prevention function and are subject to the restrictions upon disclosure set forth in this part.

§ 2.37–1 Third-party payers and funding sources.—Basis and purpose.

Section 2.37 is based upon the general authority to prescribe regulations to carry out the purposes of the authorizing legislation. The great diversity of contractual arrangements and legal requirements under which the operations of third-party payers and funding sources are carried on precludes the prescription of detailed records management instructions in these regulations, even if that were otherwise desirable. The general principles set forth in § 2.37, however, should clarify the question of coverage, and where coverage exists, provide a standard which will minimize the likelihood of violations. See also § 2.12–1(g).

§ 2.38 Employers and employment agencies.—Rules.

(a) *Disclosure permitted.* Where consent is given in accordance with § 2.31, a program may make disclosures in accordance with this section.

(b) *Eligible recipients.* A program may make disclosures under this section to public or private employment agencies, employment services, or employers.

(c) *Scope of disclosure.* Ordinarily, disclosures pursuant to this section should be limited to a verification of the patient's status in treatment or a general evaluation of progress in treatment. More specific information may be furnished where there is a bona fide need for such information to evaluate hazards which the employment may pose to the patient or others, or where such information is otherwise directly relevant to the employment situation.

(d) *Criteria for approval.* A disclosure under this section may be made if, in the judgment of the program director or his authorized representative appointed as provided in § 2.17(b), the following criteria are met:

(1) The program has reason to believe, on the basis of past experience or other credible information (which may in appropriate cases consist of a written statement by the employer), that such information will be used for the purpose of assisting in the rehabilitation of the patient and not for the purpose of identifying the individual as a patient in order to deny him employment or advancement because of his history of drug or alcohol abuse.

(2) The information sought appears to be reasonably necessary in view of the type of employment involved.

§ 2.38–1 Employers and employment agencies.—Basis and purpose.

Section 2.38 is based on the rulemaking power conferred by subsection (b)(1) of the authorizing legislation, and is adapted from § 1401.26 of the previous regulations. Its purpose is to allow disclosures reasonably necessary and appropriate to facilitate the employment of patients and former patients, while protecting patients against unnecessary or excessively broad disclosures. It was urged in a comment received on the August 22, 1974 draft that disclosures to employers be flatly prohibited on the ground that the employer's sole legitimate concern is with on-the-job performance. While we are not unsympathetic to this view, a countervailing consideration is that in the case of an employee or applicant who is known by the employer to have a problem with drugs or alcohol, knowledge by the employer of a genuine effort by the employee to deal with it can make the difference between a job and no job.

§ 2.39 Criminal justice system referrals.—Rules.

(a) *Consent authorized.* Where participation by an individual in a treatment program is made a condition of such individual's release from confinement, the disposition or status of any criminal proceedings against him or the execution or suspension of any sentence imposed upon him, such individual may consent to unrestricted communication between any program in which he is enrolled in fulfillment of such condition and (1) the court granting probation, or other post-trial or pretrial conditional release, (2) the parole board or other authority granting parole, or (3) probation or parole officers responsible for his supervision.

(b) *Duration of consent.* Where consent is given for disclosures described in paragraph (a) of this section, such consent shall expire sixty days after it is given or when there is a substantial change in such person's status, whichever is later. For the purposes of this section, a substantial change occurs in the status of a person who, at the time such consent is given, has been—

(1) Arrested, when such person is formally charged or unconditionally released from arrest;

(2) Formally charged, when the charges have been dismissed with prejudice, or the trial of such person has been commenced;

(3) Brought to a trial which has commenced, when such person has been acquitted or sentenced;

(4) Sentenced, when the sentence has been fully executed.

(c) *Revocation of consent.* An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and effective termination or revocation of such release from confinement, probation, or parole.

(d) *Restrictions on redisclosure.* Any information directly or indirectly received pursuant to this section may be used by the recipients thereof only in connection with their official duties with respect to the particular individual with respect to whom it was acquired. Such recipients may not make such information available for general investigative purposes, or otherwise use it in unrelated proceedings or make it available for unrelated purposes.

§ 2.39–1 Criminal justice system referrals.—Basis and purpose.

(a) On the basis of extensive written comment and oral communications received on the subject matter of § 2.39 as proposed in the May 9, 1975 notice (designated as § 2.40 in that notice), we have concluded that the latitude allowed and the conditions imposed in § 2.39 as set forth above are necessary and proper to effectuate the purposes of the authorizing legislation.

(b) From a legal standpoint, it seems highly doubtful whether, in a proceeding to revoke probation or parole, the due process requirements laid down in *Morrissey v. Brewer*, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed.2d 484 (1972) and *Gagnon v. Scarpelli*, 411 U.S. 778, 93 S.Ct. 1756, 36 L.Ed.2d 656 (1973) could be met by an unsupported general evaluation by a treatment program to the effect that a patient's status or progress in treatment was unsatisfactory. Thus, if such an evaluation were all that could be communicated by a program about a particular patient's conduct during the period he was in treatment, a condition requiring satisfactory participation in a treatment program would to all intents and purposes become unenforceable. Moreover, if it were held to be enforceable, the operative decision on the revocation issue would then be made by the program, arguably exacerbating rather than alleviating its role-conflict problem. It may thus be the part of wisdom to confess that some degree of role-conflict is inherent in the situation of any program which accepts criminal justice referrals. If so, the issue then becomes that of finding the most constructive way to handle the conflict, rather than a sterile and futile effort to avoid it altogether.

(c) We are persuaded that in many instances a prohibition on free communication between probation officers and drug abuse program counsellors would have profoundly deleterious effects on the rehabilitative process. Many probation officers bring to their work a high degree of training, professionalism, and experience. They are under no illusion that they are dealing with a clientelle which will never stumble or relapse, and if they have the information necessary to intervene at an early stage of such an episode, their intervention can often make the difference between success and failure for the client.

(d) There is, however, nothing in these regulations which precludes treatment programs from entering into agreements or arrangements with agencies or institutions of the criminal justice system to regulate or restrict the subject matter or form of communications of information about patients. For example, such an arrangement might provide for free oral communication between counsellors and probation officers, while restricting formal written reports by the program to specified types of so-called hard data such as attendance and urinalysis results. In view of widely differing conditions and attitudes in various parts of the country, substantial variations in such arrangements are not only expectable but desirable.

(e) A further aspect of this matter, which was not adequately considered or dealt with in the May 9 proposal, is the impact which the rules laid down in § 2.39 have on the bail decision. There is a high correlation between the disposition of the application for bail and the type of sentence which may be meted out upon conviction. The contrast between the recidivism rates for those who receive treatment and supervision, as against those who simply receive the punishment of incarceration, is a powerful argument against restrictions which would tend to narrow the circumstances under which conscientious judges can grant bail.

(f) It must be emphasized that § 2.39 in no way reduces the necessity to obtain written consent from patients, whether or not referred by the criminal justice system, before disclosures for the purposes here involved can be made by programs. We have been urged to make an exception from the requirement of § 2.31 in the case of parolees and probationers, but such an exception would be wholly unsupported by the authorizing legislation. In fashioning these regulations, it is not our privilege to adorn a tabula rasa according to our own predilections: rather, it is our duty to interlineate a statute with fidelity to its spirit, its terms, and its purposes.

§ 2.40 Situations not otherwise provided for.—Rules.

(a) *Criteria for approval.* In any situation not otherwise specifically provided for in this subpart, where consent is given in accordance with § 2.31, a program may make a disclosure for the benefit of a patient from the records of that patient if, in the judgment of the program director or his authorized representative appointed as provided in § 2.17, all of the following criteria are met:

(1) There is no suggestion in the written consent or the circumstances surrounding it, as known to the program, that the consent was not given freely, voluntarily, and without coercion.

(2) Granting the request for disclosure will not cause substantial harm to the relationship between the patient and the program or to the program's capacity to provide services in general.

(3) Granting the request for disclosure will not be harmful to the patient.

(b) *Circumstances deemed beneficial.* For the purposes of this section, the circumstances under which disclosure may be deemed to be beneficial to a patient include, but are not limited to, those in which the disclosure may assist the patient in connection with any public or private claim, right, privilege, gratuity, grant or other interest accruing to, or for the benefit of, the patient or the patient's immediate family. Examples of the foregoing include welfare, medicare, unemployment, workmen's compensation, accident or medical insurance, public or private pension or other retirement benefits, and any claim or defense asserted or which is an issue in any civil, criminal, administrative or other proceeding in which the patient is a party or is affected.

§ 2.40–1 Situations not otherwise provided for.—Basis and purpose.

(a) Section 2.40 is based upon § 1401.23 of the previous regulations, amended to reflect the expansion made by the change in the law with respect to the permissible scope of consensual disclosures.

(b) A strong case can be made for the proposition that § 2.40 should, in effect if not expressly, require a program to make any disclosure requested by a patient. The discretion vested in the program, it can be argued, is at best an expression of overprotective paternalism, and at worst, an invitation to programs to cover up material potentially embarrassing to themselves. Bearing in mind, however, that persons who have obtained the type of treatment to which this part applies are more vulnerable to pressures of various kinds than are patients in general, it seems preferable to retain some responsibility on the part of the program to protect the best interests of its patients in this very sensitive area. This, like many other choices which these regulations reflect, is a determination which can be reviewed and revised from time to time in the light of experience.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.—Rules.

(a) *In general:* Disclosure to medical personnel, either private or governmental is authorized without the consent of the patient when and to the extent necessary to meet a bona fide medical emergency.

(b) *Food and Drug Administration.* Where treatment involves the use of any drug, and appropriate officials of the Food and Drug Administration determine that the life or health of patients may be endangered by an error in the manufacture or packaging of such drug, disclosure of the identities of the recipients of the drug may be made without their consent to appropriate officials of the Food and Drug Administration to enable them to notify the patients or their physicians of the problem in order that corrective action may be taken.

(c) *Incapacitated persons.* Where a patient is incapacitated and information concerning the treatment being given him by a program is necessary to make a sound determination of appropriate emergency treatment, such information may be given without the patient's consent to personnel providing such emergency treatment.

(d) *Notification of family or others.* When any individual suffering from a serious medical condition resulting from drug or alcohol abuse is receiving treatment at a facility which is within the scope of this Part the treating physician may, in his discretion, give notification of such condition to a member of the individual's family or any other person with whom the individual is known to have a responsible personal relationship. Such notification may not be made without such individual's consent at any time such individual is capable of rational communication.

(e) *Record required.* Any program making an oral disclosure under authority of this section shall make a written memorandum showing the patient's name or case number, the date and time the disclosure was made, some indication of the nature of the emergency, the information disclosed, and the names of the individuals by whom and to whom it was disclosed.

§ 2.51–1 Medical emergencies.—Basis and purpose.

The provisions of § 2.51 are adapted from § 1401.42 of the previous regulations, and are based on subsection (b)(2)(A) of the authorizing legislation. The provision in the previous regulations with respect to patients who may be incarcerated is now covered in § 2.33(b).

Paragraph (d) of § 2.51 is based upon the theory that the disclosure there allowed is of the patient's endangered condition, not his identity as a drug or alcohol abuse patient, and that the humanitarian necessity of such notification outweights its potential for accidental violation of confidentiality

§ 2.52 Research, audit, and evaluation.—Rules.

(a) *Research, audit, and evaluation.* Subject to any applicable specific provision set forth hereinafter in this subpart, the content of records pertaining to any patient which are maintained in connection with the performance of a function subject to this part may be disclosed, whether or not the patient gives consent, to qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner. For the purposes of this subpart and for the purposes of subsection (b)(2)(B) of the authorizing legislation, the term "qualified personnel" means persons whose training and experience are appropriate to the nature and level of the work in which they are engaged and who, when working as part of an organization, are performing such work with adequate administrative safeguards against unauthorized disclosures.

(b) *Use of disclosures of patient identifying information.*

(1) Where a disclosure made to any person pursuant to paragraph (a) of this section includes patient identifying information with respect to any patient, such information may not be further disclosed, and may not be used in connection with any legal, administrative, supervisory, or other action whatsoever with respect to such patient, except as provided in paragraphs (b)(2) and (b)(3) of this section.

(2) The inclusion of patient identifying information in any written or oral communication between a person to whom a disclosure has been made pursuant to paragraph (a) and the program making such disclosure does not constitute the identification of a patient in a report or otherwise in violation of paragraph (a).

(3) Where a disclosure is made pursuant to paragraph (a) of this section to a person qualified to determine, on the basis of such disclosure, the presence of a substantial risk to the health and well being, whether physical or psychological, of any patient, and, in the judgment of such person, such a risk exists and the situation cannot be dealt with solely by means of communications as described in paragraph (b)(2) of this section without intensifying or prolonging the risk as compared with other means of dealing with it, then the initial disclosure under paragraph (a) and any subsequent disclosure or redisclosure of patient identifying information for the purpose of reducing the risk to the patient involved shall be subject to the provisions of § 2.51.

§ 2.52–1 Research, audit, and evaluation.—Basis and purpose.

(a) *General purpose.* Subsection (a) of this section is adapted directly from subsection (b)(2)(B) of the authorizing legislation. The purpose of each is the same: To facilitate the search for truth, whether in the context of scientific investigation, administrative management, or broad issues of public policy, while at the same time safeguarding the personal privacy of the individuals who are the intended beneficiaries of the process or program under investigation. This subpart in particular, and this part as a whole, are intended to aid in carrying out that purpose.

(b) The succeeding sections of this subpart deal with problems which arise in connection with disclosures made for certain specific purposes which have been interpreted as falling within the general purposes embraced by § 2.52. Those sections will be best understood, however, in the light of some discussion of the underlying premises of the general rule, and its relationship to two other legal concepts: the right of privacy, and the duty to obtain informed consent from research subjects.

(c) *The Right of Privacy.* So far as is relevant to this discussion, we may consider the right of privacy in two aspects. One, a protection against improper governmental activity, is the right to be secure against unreasonable searches and seizures guaranteed by the Fourth Amendment, with some expansion from the penumbras of the Fifth and Sixth Amendments. The protections afforded to patients by the authorizing legislation, not to mention these regulations, go far beyond those which are constitutionally required.

(d) The other aspect of the right of privacy, which has sometimes been described as the right to be left alone, is the notion that an individual has a right not to be hurt by intrusions into his essentially personal concerns, or to have essentially private information exploited for commercial gain, whether or not the intrusion or exploitation is in connection with any possible governmental action against him. The courts have spoken of a right of privacy in a wide variety of contexts, but they have repeatedly and explicitly rejected the notion that anyone has a right to go about his daily affairs encapsulated in an impenetrable bubble of anonymity. The courts have been careful to weigh the competing interests, and the social interest in valid research and evaluation is clearly of sufficient moment to be considered in this process.

(e) In defense of the position that disclosure of patient identifying information even for carefully guarded scientific research should be permitted only on a consensual basis, two dominant lines of argument, somewhat interrelated, have emerged. One is that retrospective studies are of questionable value in any case, and the other is that a sampling technique involving informed consent on the part of the members of the sample can always be used to develop the information sought. Neither line of argument will withstand careful scrutiny.

(f) It is true, of course, that the efficacy of a given therapeutic agent can often best be evaluated by means of a well-designed prospective study in which special recordkeeping procedures, special criteria for patient selection, and an appropriate control have all been established with a view to the purpose of the study. There are, however, many important investigations which simply do not lend themselves to such a format. Sometimes the desirability or even the possibility of a particular study does not suggest itself except in retrospect. Another important consideration is the fact that knowledge that an investigation is going on may influence the behavior of patients, clinicians, or both. Where such knowledge can influence the make-up of a sample, it will normally do so in the direction of favorable outcomes, but to an unknown degree, thus tending to invalidate the results reported.

(g) While the sample technique has its uses, especially with populations that are unmanageably large, it is often less difficult and expensive, and less likely to interfere with the actual conduct and outcomes of treatment or rehabilitation processes, to use the full population under study. Even more important than economy and administrative convenience in carrying out a study, there may be an overriding advantage in terms of eliminating any question as to the validity of the results of the study on the ground of bias in the selection of the sample.

(h) *Informed Consent*. The duty to obtain informed consent is obvious and compelling in situations where an individual is exposed to the possibility of harm, either physical or psychological, as a consequence of medical procedures, research, or similar activities. Where such a situation exists the person conducting the research or medical procedure violates his duty to the subject or patient if he proceeds without obtaining the voluntary informed consent from the individual or his legally authorized representative. Thus, in conducting an activity which places the subject or patient at risk the practitioner may not give precedence to a hidden agenda, even for so lofty a motive as the advancement of knowledge. In this regard, see the Department of Health, Education and Welfare's Protection of Human Subjects Regulations, 45 CFR Part 46. Those regulations are applicable to all Department of Health, Education and Welfare grants and contracts supporting research, development and related activities involving human subjects.

(i) It is apparent that the foregoing rationale for requiring informed consent does not apply to the same degree in situations involving the disclosure of clinical records for research in the form of follow-up or retrospective studies. Under these circumstances the risk to the subject is that some disclosure or misuse of information from which he could be identified might result in embarrassment, lost opportunities, or other forms of psychological or social injury. While that possibility of harm could be reduced by requiring consent to every review of clinical records for research purposes, a similar result can be achieved by the less restrictive method of limiting further disclosure of identifying information by the researcher. Given the applicability of this alternative, equally effective means for protecting a patient or subject from the possibility of a harmful public disclosure, it is unreasonable to insist upon informed consent to every review of clinical records for the purposes of conducting legitimate research, particularly since such insistence could lead to the ultimate absurdity of prohibiting efforts to identify the nature and source of an unknown plague simply because the patients or researcher lacked the clairvoyance to have consent forms signed prior to the onset of the affliction.

(j) In sum, there are restraints on certain means of governmental acquisition of information about individuals which are operative irrespective of how the information is used, and there are restraints on the uses of information which are independent of how or by whom it is acquired, but they do not and should not add up to the proposition that the use of information about a person is either morally or legally the absolute prerogative of that person to determine.

(k) For all of these reasons, the authorizing legislation expressly provides that patient consent is not required with respect to disclosures for research, audit, and evaluation, nor does it prohibit individual patient identification in connection with such disclosures. While it is entirely appropriate to impose safeguards and procedures in connection with these activities, it would be wholly inappropriate to use the rulemaking process to impose an absolute requirement of patient consent with respect to activities which by statute may be conducted without it.

(l) *Classification of activities*. It is clear that Congress intended a balancing of the social interest in the validity of the results of inquiry, on the one hand, with the individual interest in anonymity, on the other, all within the limits set by the legislation and the constitution. With that objective in mind, we may now turn to the various categories of activities which come within the purview of this subpart.

(m) These activities may be classified first, in regard to whether participation is voluntary from the standpoint of the program, and second, as to whether the objective is to ascertain compliance with predetermined standards (examinations as defined in § 2.54, and program evaluation as defined in § 2.11(g)(1)), or to ascertain the validity of a given standard or hypothesis (scientific research, and program evaluation as defined in § 2.11 (g)(2)). The application of the foregoing classifications logically results in the creation of four categories of activities. Three of them are specifically dealt with in the succeeding sections of this subpart and need not detain us here; the fourth is discussed below.

(n) *Scientific research and evaluation*. Beyond the bare restatement of the authorizing legislation set forth in § 2.52, these regulations are deliberately silent with respect to purely voluntary scientific research and program evaluation in the sense defined in § 2.11(g)(2). Testimony and written comments received on the August 22, 1974 draft regulations were noteworthy in two respects. First, no instances of abuse on the part of persons acquiring patient identifying information under these circumstances were cited. Second, while there was some well-founded criticism of the attempt in that draft to provide guidelines for determining what is scientific research and who is qualified to do it, no usable alternatives—indeed, almost no alternatives at all—were forthcoming.

(o) In one of the written comments, the writer cautioned against any assumption "that our major remaining problems in drug and alcohol abuse treatment are prevention of illicit diversion and protection of confidentiality," and suggested "that we still have a problem in discovering, testing and evaluating improved treatment techniques. To do this," he continued, "one should place minimal obstacles in the way of bona fide clinical and epidemiologic research!"

(p) The result of leaving the rule as it is in the statute, without attempting to sharpen its outlines or define its terms, will be to leave it for interpretation on a case-by-case basis by those who must apply it in practice: the researchers who seek the information, and the programs which supply it. This does not foreclose the possibility of amending the regulations on the basis of experience if it appears either that clinicians are becoming so cautious that research and evaluation studies are being choked off, or that abuses are occurring in the use of information disclosed. But until a need for more detailed regulation in this area is demonstrated, we think its imposition would do more harm than good.

§ 2.53 Governmental agencies.—Rules.

(a) *In general*. Where research, audit, or evaluation functions are performed by or on behalf of a State or Federal governmental agency, the minimum qualifications of personnel performing such functions may be determined by such agency, subject to the provisions of this part, with particular reference to the organizational requirements and limitations on the categories of records subject to review by different categories of personnel.

(b) *Financial and administrative records*. Where program records are reviewed by personnel who lack either the responsibility for, or appropriate training and supervision for, conducting scientific research, determining adherence to treatment standards, or evaluating treatment as such, such review should be confined as far as practicable to administrative and financial records. Under no circumstances should such personnel be shown caseworker or counsellor notes, or similar clinical records. Programs should organize their records so that financial and administrative matters can be reviewed without disclosing clinical information and without disclosing patient identifying information except where necessary for audit verification.

(c) *Scientific research and long-term evaluation studies.* No State and no agency or political subdivision of a State may require, as a condition to funding, licensing, or otherwise, that any program furnish patient identifying information for the purpose of conducting scientific research or long-term evaluation studies unless the recipient of such information is legally required to hold such information in confidence, is prohibited from taking any administrative, investigative, or other action with respect to any individual patient on the basis of such information, and is prohibited from identifying, directly or indirectly, any individual patient in any report of such research or evaluation, or otherwise disclosing patient identities in any manner.

(d) *Opinion and description to be furnished program.* Before any patient identifying information is required to be submitted by a program under the circumstances described in paragraph (c), the program shall be furnished—

(1) An opinion by the attorney general or other chief legal officer of the State to the effect that the conditions specified in paragraph (c) are fulfilled with respect to such program or with respect to all programs in such State similarly situated, and

(2) A description of the administrative procedures and physical limitations on access or other measures to provide for the security of the data, but such description shall not be in such detail as to furnish guidance for wrongful attempts to breach such security.

(e) *Exclusiveness of procedures.* No State or local governmental agency may require any treatment program to furnish patient identifying information to itself or any other recipient except in conformity with this section or § 2.54. No Federal agency may require any treatment program to furnish patient identifying information to itself or any other recipient except in conformity with this section (other than paragraph (d)(1) thereof) or § 2.54.

§ 2.53-1 Governmental agencies.—Basis and purpose.

Section 2.53 is an implementation of the authority contained in subsection (g) of the authorizing legislation to provide safeguards and procedures to effectuate the purposes of such legislation. It makes clear that whenever information is required of a program, whether by law or by the terms or conditions of a contract or grant, the procedures and safeguards required under this section are applicable.

§ 2.54 Patient identifying information in connection with examinations.—Rules.

(a) *Definitions.* For the purposes of this section—

(1) The term "examination" means any examination to which this section is made applicable by paragraph (b) of this section.

(2) The term "examiner" means any individual or any public or private organization, including any Federal, State, or local governmental agency, which conducts an examination to which this section applies.

(b) *Applicability.* This section applies to any examination of the records of a treatment program which is carried out for the purpose of or as aid to ascertaining the accuracy or adequacy of its financial or other records, or the efficiency or effectiveness of its financial, administrative, or medical management, or its adherence to financial, legal, medical, administrative, or other standards, regardless of whether such examination is called an audit, an evaluation, an inspection, or by any other name.

(c) *Statement required for disclosure of patient identifying information in connection with examination.* No program may make, and no examiner may require, any disclosure of patient identifying information in connection with an examination unless the examiner furnishes to the program a written statement—

(1) that no record of patient identifying information will be made or retained by or on behalf of the examiner in connection with the examination without notice to the program in accordance with paragraph (c)(2) of this section, or

(2) setting forth the specific purpose for which a record of patient identifying information is being retained by or on behalf of the examiner, the location at which such information will be kept, and the name, official title, address, and telephone number of a responsible individual to whom any inquiries by the program about the disposition of such record should be directed.

(d) *Disposition of record of patient identifying information in connection with examination.* After any record of patient identifying information retained in connection with an examination has served its purpose, or within the time prescribed in paragraph (e) of this section, whichever is earlier, the examiner shall destroy or return to the program all records (including any copies thereof) containing patient indentifying information which have been in its possession in connection with such examination.

(e) *Maximum time allowed for disposition.* The action required by paragraph (d) shall be completed—

(1) Except as provided in paragraph (e)(2) of this section not more than two years after the record was acquired by or on behalf of the examiner, or

(2) Where the record is needed in connection with a formal legal proceeding against the program commenced or to be commenced not more than two years after the record was acquired, and written notice to this effect is furnished to the program within two years after the record was acquired, not later than the termination of such proceeding.

(f) *Notice of final disposition.* When an examiner disposes of records as required by paragraph (d) of this section, or not later than the time prescribed by paragraph (e) of this section, whichever is earlier, the examiner shall furnish to the program concerned a written statement—

(1) That there has been compliance with this section and with the provisions of this part prohibiting any disclosure of patient identifying information from records held by auditors or evaluators, or

(2) Specifying the particulars in which there has been a failure of compliance.

§ 2.54-1 Patient identifying information in connection with examina~~tions.—Basis and purpose~~.

Confidence on the part of treatment program personnel in the integrity of auditing and regulatory processes is important to the effective functioning of the treatment system. It is the purpose of § 2.54 to foster practices which will both justify and engender such confidence.

§ 2.55 Supervision and regulation of narcotic maintenance and detoxification programs.—Rules.

(a) *Definition of "registrant".* For the purposes of this section, the term "registrant" means a person who (1) has pending an application for registration under section 303(g) of the Controlled Substances Act (21 U.S.C. 823 (g)), or (2) has been registered under such section and whose registration has not expired or been surrendered or revoked.

(b) *Drug Enforcement Administration.* Duly authorized agents of the Drug Enforcement Administration shall have access to the premises of registrants for the purpose of ascertaining compliance (or ability to comply) with standards established by the Attorney General under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) respecting the security of stocks of narcotic drugs and the maintenance of records (in accordance with section 307 of the Controlled Substances Act, 21 U.S.C. 827) on such drugs. Registrants shall maintain such records separate from and in addition to patients' clinical records required to be maintained under 21 CFR 310.505 (d)(7)(iii), which shall not be available to such agents except as authorized under a court order in accordance with Subpart E of this part. Records maintained by registrants for the purposes of section 307 of the Controlled Substances Act (21 U.S.C. 827) need not identify patients by name, address, social security number, or otherwise except by an identifying number assigned by the registrant, but where such a system is used, the registrant shall maintain on a current basis a cross-index referencing each identifying number to the name and address of the patient to whom it refers. Upon request at any time and wtihout advance notice, but subject to the provisions of § 2.54, such agents shall be granted immediate access to any such index. Such agents may use names and addresses so obtained strictly for the purposes of auditing or verifying program records, and shall exercise all reasonable precautions to avoid inadvertent disclosure of patient identities to third parties. Names and other identifying information so obtained may not be compiled or used in any registry or personal data bank of any description.

(c) *Food and Drug Administration*. Duly authorized agents of the Food and Drug Administration shall have access to the premises of registrants and to all records maintained by registrants, for the purpose of ascertaining compliance (or ability to comply) with standards established by the Secretary of Health, Education and Welfare under section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (42 U.S.C. 257a), sections 303(g)(1) and 303(g)(3) of the Controlled Substances Act (21 U.S.C. 823(g)(1) and 823(g)(3)), and sections 505 and 701(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 and 371(a)). When necessary in the conduct of their duties, and subject to the provisions of § 2.54, agents may use names and addresses of patients strictly for the purposes of auditing or verifying program records, and shall exercise all reasonable precautions to avoid inadvertent disclosure of patient identities to third parties. Names and other identifying information on patients obtained pursuant to this section or by any other compulsory process may not be compiled or used in any registry or personal data bank of any description. Except as authorized under this paragraph or by a court order granted under Subpart E of this part, (1) such agents may not, either orally or in writing, except in conversation with personnel of the registrant while on the premises of the registrant, identify any patient otherwise than by reference to an identifying number assigned by the registrant, and (2) such agents may not remove from the premises of the registrant any notes, documents, or copies thereof which contain patient identifying information.

(d) *State drug law enforcement agencies*. Duly authorized agents of any State drug law enforcement agency having jurisdiction and specific responsibility by statute or otherwise for the enforcement of criminal laws relating to controlled substances (as defined in the Controlled Substances Act) shall have access to the premises of any registrant for the purposes (with respect to corresponding provisions, if any, of State law) and subject to the restrictions and limitations set forth in paragraph (b) of this section, and subject to § 2.54.

(e) *State health authorities*.

(1) *Definition of "qualified State health agency"*. As used in this paragraph, the term "qualified State health agency" means an agency of State government (i) which has express legal responsibility to ascertain that registrants under its jurisdiction comply with appropriate treatment standards; (ii) which is legally and administratively separate from any agency of State government responsible for investigation of violations of, or enforcement of, criminal law generally or criminal laws relating to controlled substances; (iii) whose personnel are qualified by training or experience to conduct inspections of health care facilities to ascertain compliance with treatment standards; and (iv) whose personnel are by State law, or by published administrative directive enforced by effective sanctions, required to maintain the confidentiality of any information concerning the identity of patients which they may acquire in the course of their official duties.

(2) *Access*. Duly authorized agents of a qualified State health agency shall have access to the premises of registrants and to all records maintained by registrants, for the ~~purpose of ascertaining~~ compliance (or ability to comply) with treatment standards (including those relating to quantities of narcotic drugs which may be provided for unsupervised use by individuals in treatment) established under State law. Such access, and the use of any information thereby obtained, shall be subject to the restrictions and limitations set forth in paragraph (c) of this section, and subject to § 2.54.

§ 2.55-1 Supervision and regulation of narcotic maintenance and detoxification programs.—Basis and purpose.

(a) Section 2.55 is addressed to the general problem described in the following passage from the legislative history of Pub. L. 93-282:

> A major element of the task of fashioning new regulations pursuant to the express rulemaking authority conferred by this legislation will be to reconcile the sometimes conflicting interests of research, audit, and evaluation with rights of privacy and the confidentiality of the relationship between patient and clinician. Such a reconciliation becomes particularly crucial where the functions of research, audit, or evaluation are conducted by a governmental agency with regulatory powers and responsibility, and the treatment involves the use of a drug such as methadone which is in a research status or which is readily susceptible of misuse or illicit diversion.
>
> Because of the difficulty and complexity of the task, the rulemaking authority is intentionally cast in terms broad enough to permit the limitation of the scope, content, or circumstances of any disclosure under subsection (b), whether (b)(1) or (b)(2), in the light of the necessary purposes for which it is made or required. (Congressional Record, daily edition, May 6, 1974, page H3563).

(b) It has been the consistent interpretation of the Special Action Office for Drug Abuse Prevention that the only provision of the authorizing legislation which permits disclosures to compliance officers, whether of DEA, FDA, or state agencies, is subsection (b)(2)(B). That subsection strictly prohibits any further disclosure of names or other identifying information concerning patients, and the statutory prohibition has been buttressed by provisions of these regulations, notably § 2.54, providing safeguards and procedures to assure that the statutory prohibition is respected.

(c) In testimony and written comment on the August 22, 1974 draft of these regulations, it has been urged that access to patient identifying information by law enforcement personnel, even for the limited purposes allowed by statute and regulation, should be prohibited except pursuant to a court order obtained under 21 U.S.C. 1175(b)(2)(C). We believe that such a prohibition is beyond our power to impose.

(d) Section 307(b) of the Controlled Substances Act (21 U.S.C. 827) provides, in pertinent part, "Every * * * record required under this section * * * shall be kept and be available, for at least two years, for inspection and copying by officers or employees of the United States authorized by the Attorney General." It is a well known principle of statutory construction that amendments and repeals by implication are not favored. In *People v. Newman*, 32 N.Y.2d 379, 345 N.Y.S.2d 502, 298 N.E.2d 651 (1973), cert. denied 414 U.S. 1163, 94 S.Ct. 927, 39L. Ed. 2d 116 (1974), the United States filed *amicus* briefs with the Court of Appeals of New York and with the United States Supreme Court, arguing that section 408 of Pub. L. 92-255 (21 U.S.C. 1175) did not effect an implied amendment or repeal of the provisions of Pub. L. 91-513 (21 U.S.C. 872(c) and 42 U.S.C. 242a(a)) which confer on the Attorney General and the Secretary of Health, Education, and Welfare the power to grant the so-called research privilege discussed in § 2.24. This position was expressly adopted by the New York court. We cannot now take the inconsistent position that section 408 of Pub. L. 92-255 did indeed amend by implication section 307 of Pub. L. 91-513, particularly in the face of a contrary contemporaneous administrative interpretation by both the Special Action Office for Drug Abuse Prevention and the Department of Justice. In short, if the right of access and copying conferred on Federal agents by 21 U.S.C. 827 is to be amended to provide that it may only be exercised pursuant to a court order in the case of maintenance and detoxification programs, that is a change which must be wrought by the Congress.

(e) In the case of inspections carried out by health supervisory agencies, we think that denial of access to any documents showing patient identifying information may have a serious adverse effect on the validity of the inspection process. Even if a program keeps its own records in terms of patient-identifying numbers assigned by the program, the patient file may contain—may, indeed, be required to contain—documents signed by the patient or originating outside the program. Where signatures, names, and addresses are all obliterated, it is impossible for the inspector to check the file even for apparent internal consistency. We believe that outright forgery is and will remain a rarity, but the temptation to cover improper or inadequate documentation by "accidental misfilings" may be something else again.

(f) From a legal standpoint, the term "audit" has long comprehended the notion of external verification. In a commercial setting, this means that at least some inventory will actually be counted, at least some receivables will be verified by contacting the customers, and so on. To rule that this crucial aspect of the audit process cannot be carried out with respect to a treatment program until after the auditor goes through the procedure of obtaining a specific court order under subsection (b)(2)(C) would seem to contravene the intent of subsection (b)(2)(B).

(g) In all of this, our decisions must be illuminated by a balanced consideration of the best interests of the patient no less than a desire to foster the implementation of cherished values in society at large. If protection of the patient's right to privacy is achieved by means which seriously impair our ability to protect him from exploitation and malpractice, not to mention the diversion of funds intended for his benefit, it would be a hollow victory indeed. We believe that the procedures and safeguards which these regulations impose on the conduct of audits and evaluations will avoid that result, while affording substantial and meaningful new protection to the confidentiality of patient records.

§ 2.56 Prohibition on disclosure of patient identities from research, audit, or evaluation records—Rules.

Where the content of patient records has been disclosed pursuant to this subpart for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, information contained therein which would directly or indirectly identify any patient may not be disclosed by the recipient thereof either voluntarily or in response to any legal process whether Federal or State. This prohibition does not affect the accessibility of the original records under authority of a court order referred to in subpart E.

§ 2.56–1 Prohibition on disclosure of patient identities from research, audit, or evaluation records—Basis and purpose.

Section 2.56 restates the prohibition on further disclosure which is contained in subsection (b)(2)(B) of the authorizing legislation. The relationship of the provisions authorizing court orders to the provisions authorizing disclosure for research, audit, and evaluation, is dealt with in § 2.62.

Subpart E—Court Orders

§ 2.61 Legal effect of order—Rules.

Subsection (b)(2)(C) of the sections which authorize this part (21 U.S.C. 1175 and 42 U.S.C. 4582) empowers the courts, in appropriate circumstances, to authorize disclosures which would otherwise be prohibited by subsection (a) of those sections. Subsection (b)(2)(C) operates only as a mechanism for the relief of the duty imposed by subsection (a) and not as an affirmative grant of jurisdiction to authorize or compel disclosures prohibited or privileged by other provisions of law, whether Federal or State. An order or provision of an order based on some other authority, or a subpoena, or other appropriate legal process, is required to compel disclosure. To illustrate, if a person who maintains records subject to this part is merely requested, or is even served with a subpoena, to disclose information contained therein in a manner prohibited in the absence of a court order, he must refuse such a request unless, and until, an order is issued under subsection (b)(2)(C). Such an order would remove the prohibition, but could not, of its own force, require disclosure. If there were no subpoena or other compulsory process, or a subpoena had been issued but had expired or been quashed, the custodian of the records would have discretion as to whether to disclose the information sought unless and until disclosure were ordered by means of appropriate legal or administrative process, the authority for which would have to be found in some source other than subsection (b)(2)(C) of the sections authorizing this part.

§ 2.61–1 Legal effect of order—Basis and purpose.

(a) Section 2.61 is a restatement of the interpretative rules embodied in §§ 1401.61 and 1401.62 of the previous regulations. Both the positioning of the authority to issue court orders in S. 2097 as initially passed by the Senate (92nd Congress, 1st Session, December 2, 1971) and the explicit cross-reference in section 408(a) of Pub. L. 92-255 make clear the congressional intent that section 408(b)(2)(C) operate as a mechanism for the relief of the 408(a), strictures and not as an affirmative grant of jurisdiction to authorize disclosures prohibited by other provisions of law, whether Federal or State.

(b) The amendment made by Pub. L. 93-282 to section 333 of the Alcoholism Act (42 U.S.C. 4582) was enacted with the same language and structure as section 408 in this regard in order to make the interpretative rules set forth in § 2.61 applicable to it.

§ 2.62 Inapplicability to secondary records—Rules.

The authority which subsection (b)(2)(C) of the sections which authorize this part (21 U.S.C. 1175 and 42 U.S.C. 4582) confers on courts to issue orders authorizing the disclosure of records applies only to records referred to in subsection (a) of such sections, that is, the records maintained by treatment or research programs which have patients, and not to secondary records generated by the disclosure of the subsection (a) records to researchers, auditors, or evaluators pursuant to subsection (b)(2)(B).

§ 2.62–1 Inapplicability to secondary records—Basis and purpose.

(a) The interpretative rule set forth in § 2.62 is an essential and basic limitation on the scope of (b)(2)(C) orders. It was part of the original regulations under section 408 of Pub. L. 92-255 published November 17, 1972 (37 FR 24638), and was carried forward unchanged in the amended regulations published December 6, 1973 (38 FR 33748), the special status of which has already been noted in § 2.3. See, also, § 2.61-1.

(b) Although this rule is well supported by the history and technical structure of the legislation, the policy considerations in its favor are even more compelling. In § 2.52-1, we have discussed the urgent necessity for access, even without patient consent, to patient records on the part of qualified personnel engaged in scientific research and evaluation. Where this access includes patient identifying information, as it sometimes must if vital work is to be done, there must not be any question whatsoever about the legal inviolability of its confidential status in the hands of the researcher. Granted, there may occur rare occasions when the original records are for some reason not available, where a (b)(2)(C) order would lie as to the original records, and where there would seem to be some advantage in the administration of justice for such an order to permit disclosure of identifying information by the researcher. But compared to the damage which the mere potentiality for access does to the whole research enterprise, the advantage in terms of ability to deal with rare and anomalous cases seems almost trivial. Even in those cases, denial of access to the party seeking the information leaves him in no worse position than if the research or evaluation, which was certainly not undertaken for his benefit, had never been done at all.

(c) Where the secondary records are generated under the circumstances described in § 2.54, of course, this argument does not apply. In that situation, if preliminary examination suggests that the records may be needed for compliance or other administrative or judicial proceedings, the person conducting the audit or other examination should promptly seek the authority of a court order to copy the original records. The use of secondary records thus generated under authority of a court order would then be limited by the terms and purposes of the order, rather than subsection (b)(2)(B) of the authorizing legislation, and thus the rule set forth in § 2.62 would not apply.

§ 2.63 Limitation to objective data—Rules.

(a) *Limitation to objective data.* Except as provided in paragraph (b) of this section, the scope of an order issued pursuant to this subpart may not extend to communications by a patient to personnel of the program, but shall be limited to the facts or dates of enrollment, discharge, attendance, medication, and similar objective data, and may include only such objective data as is necessary to fulfill the purposes for which the order is issued.

(b) *Exception.* When a patient in litigation offers testimony or other evidence pertaining to the content of his communications with a program, an order under this subpart may authorize the submission of testimony or other evidence by the program or its personnel.

§ 2.63–1 Limitation to objective data.—Basis and purpose.

In the three-year period subsequent to the original enactment of 21 U.S.C. 1175, not a single occasion was reported to the Special Action Office for Drug Abuse Prevention on which an attempt was made to secure a (b)(2)(C) order authorizing the disclosure of a confidential communication by a patient to a counsellor or other member of the staff of a treatment program. In all of the comments and testimony received on the draft regulations published August 22, 1974, there was nothing to suggest any circumstances under which a court order authorizing such a disclosure would be either desirable or appropriate. Yet the mere possibility that such an order might be issued is to some a source of anxiety which impairs the effectiveness of treatment. Such an ongoing negative effect clearly outweighs the remote theoretical possibility that some peculiar circumstance might arise in which judicial authorization for such a disclosure might be sought. Accordingly, the limitation imposed by § 2.63 on the scope of (b)(2)(C) orders to preclude that possibility, and hence to eliminate its adverse influence on treatment services, appears to be a proper exercise of rulemaking power.

§ 2.64 Procedures and criteria in general—Rules.

(a) *Identity of patient.* Applications for court orders to authorize disclosure of records pertaining to a known patient shall not use the real name of the patient unless the patient consents thereto voluntarily and intelligently. In the case of an *ex parte* application initiated by the patient, the application should be instituted in the name of a fictious person, such as Jon Doe, unless the patient requests otherwise. The same procedure should be followed in the case of a separate proceeding held in conjunction with a pending criminal or civil action. Any court order should identify the patient fictitiously, and the disclosure of the patient's real name should be communicated to the program in such manner as to protect the confidentiality of the patient's identity.

(b) *Notice.* In any proceeding not otherwise provided for in this subpart, in which the patient or the program has not been made a party, each shall be given appropriate notice and an opportunity to appear in person or to file a responsive statement, deposition or other form of response consistent with local rules of procedure. The court shall give due consideration to any such statement, deposition or other response in exercising its discretion as to the existence of good cause and, if deemed necessary or desirable, consistent with local rules of procedure, it may order the program director to appear and give direct testimony.

(c) *Hearings.* All hearings and all evidence in connection therewith shall be held or taken in the judge's chambers, unless the patient requests an open hearing or the court determines that such hearing is consistent with the public interest and the proper administration of justice.

(d) *Good cause.* No order shall be issued unless the record shows that good cause exists, and in assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

(e) *Need for disclosure.* If other competent evidence or sources of information are available, the court should ordinarily deny the application.

(f) *Adverse effects.* If there is evidence that disclosure would have an adverse effect upon successful treatment or rehabilitation of the patient or would impair the effectiveness of the program, or other programs similarly situated, in the treatment or rehabilitation of other patients, the application should be denied unless the court finds that the adverse effects are outweighed by other factors.

(g) *Content of order.* Any order authorizing disclosure shall—

(1) Limit disclosure to those parts of the patient's record deemed essential to fulfill the objective for which the order was granted;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include any other appropriate measures to keep disclosure to a minimum for the protection of the patient, the physician-patient relationship and the treatment services.

(h) *Applications not otherwise provided for.* In any case not otherwise provided for in this subpart, application for an order authorizing disclosure of records to which this part applies may be made by any person who has a legally cognizable interest in obtaining such disclosure.

§ 2.64–1 Procedures and criteria in general.—Basis and purpose.

Section 2.64, in accordance with subsection (g) of the authorizing legislation, sets out procedures and criteria for the issuance of (b)(2)(C) orders in general, subject to the more specific provisions with respect to particular types of proceedings covered in the succeeding sections of this subpart.

§ 2.65 Investigation and prosecution of patients.—Rules.

(a) *Applicability.* This section applies to any application by an investigative, law enforcement [illegible] prosecutorial agency for an order to permit disclosure of patient records for the purpose of conducting an investigation or prosecution of an individual who is, or who is believed to be, a present or former patient in a program.

(b) *Notice.* Except where an order under § 2.66 is sought in conjunction with an order under this section, any program with respect to whose records an order is sought under this section shall be notified of the application and afforded an opportunity to appear and be heard thereon.

(c) *Criteria.* A court may authorize disclosure of records pertaining to a patient for the purpose of conducting an investigation of or a prosecution for a crime of which the patient is suspected only if the court finds that all of the following criteria are met:

(1) The crime was extremely serious, such as one involving kidnapping, homicide, assault with a deadly weapon, armed robbery, rape, or other acts causing or directly threatening loss of life or serious bodily injury, or was believed to have been committed on the premises of the program or against personnel of the program.

(2) There is a reasonable likelihood that the records in question will disclose material information or evidence of substantial value in connection with the investigation or prosecution.

(3) There is no other practicable way of obtaining the information or evidence.

(4) The actual or potential injury to the physician-patient relationship in the program affected and in other programs similarly situated, and the actual or potential harm to the ability of such programs to attract and retain patients, is outweighed by the public interest in authorizing the disclosure sought.

(d) *Scope.* Both disclosure and dissemination of any information from the records in question shall be limited under the terms of the order to assure that no information will be unnecessarily disclosed and that dissemination will be no wider than necessary. Under no circumstances may an order under this section authorize a program to turn over patient records in general, pursuant to a subpoena or otherwise, to a grand jury or a law enforcement, investigative, or prosecutorial agency.

(e) *Counsel.* Any application to which this section applies shall be denied unless the court makes an explicit finding to the effect that the program has been afforded the opportunity to be represented by counsel independent of counsel for the applicant, and in the case of any program operated by any department or agency of Federal, State, or local Government, is in fact so represented.

§ 2.65–1 Investigation and prosecution of patients—Basis and purpose.

(a) The need for objective criteria for the issuance of court orders in connection with investigation or prosecution of patients seems particularly pressing. In the absence of such criteria, the assurance of confidentiality otherwise provided for by the authorizing legislation may be felt to be of little value.

(b) It has not been found possible to frame entirely satisfactory rules for the scope of orders under § 2.65, but an illustration may be helpful. Where a witness to a crime is believed capable of identifying a suspect by appearance, and the criteria set forth in § 2.65(c) are met, and the program has photographs of its patients, the witness alone may be permitted to view the photographs, with no names attached. If the witness failed to identify any photograph as being a picture of the suspect, that would end the matter. If there was such an identification, the program would be authorized to give any information in its possession as to the suspect's identity and whereabouts to appropriate authorities.

(c) It is not the purpose of this section to substitute a mechanical formula for judicial discretion, but rather to provide criteria which define the area within which discretion is to be exercised. The reason for including all crimes committed on program premises or against program personnel is not any special solicitude for programs as opposed to other victims of crime, but is rather the result of the special difficulties which the broad definition of "records" in § 2.11(o) creates for program personnel as complaining witnesses.

(d) In regard to § 2.65(e), experience has demonstrated that independent counsel may be of crucial importance. The leading case construing 21 U.S.C. 1175, *People v. Newman*, 32 N.Y.2d 379, 345 N.Y.S.2d 502, 298 N.E.2d 651 (1973); certiorari denied, 414 U.S. 1163, 94 S.Ct. 927, 39 L. Ed.2d 116 (1974), would never have been presented to the courts but for the fact that legal counsel for Dr. Newman was furnished on a *pro bono publico* basis by a private law firm. In an entirely different case, a United States District Court appears to have issued a wholly inappropriate order under 21 U.S.C. 1175 in a case in which the treatment program involved was operated by an agency of the United States Government, and either was unrepresented, or was represented by the same attorney who represented the agency seeking the order. It is possible, of course, that the order would have been issued in any event, but it seems clear that there was no adequate presentation to the court of arguments or testimony in opposition. It is difficult to see how the purposes of subsection (b)(2)(C) of the authorizing legislation can be carried out if there is inadequate presentation of the issues to the courts which must decide them.

§ 2.66 Investigation and prosecution of programs.—Rules.

(a) *Applicability.* This section applies to any application by an administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency for an order to permit disclosure of patient records or the making of copies thereof (including patient identifying information) for the purpose of conducting an investigation or an administrative or judicial proceeding with respect to any program or any principal, agent, or employee thereof in his capacity as such.

(b) *Notice.* An application under this section may, in the discretion of the court, be granted without notice, but upon the implementation of any order so granted, the program shall be afforded an opportunity to seek the revocation or amendment of such order.

(c) *Scope.* Both disclosure and dissemination of any information from the records in question shall be limited under the terms of the order to assure that patient identities will be protected to the maximum practicable extent, and that names and other identifying characteristics of patients are expunged from any documents placed in any public record. No information obtained pursuant to an order under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65.

§ 2.66–1 Investigation and prosecution of programs—Basis and purpose.

The principal purpose of § 2.66 is to enable a regulatory agency whose inspection or other source of information has disclosed a need for follow-up, or which has been refused access to patient records, to obtain the necessary authorization for access and copying. There may also be rare instances, such as those involving financial fraud, tax evasion, or other offenses where access by other investigative agencies is necessary, subject to the requirements and protections of this part.

§ 2.67 Undercover agents and informants—Rules.

(a) *Applicability.* This section applies to any application by an administrative, regulatory, supervisory, investigative, or law enforcement agency for an order to permit such agency to have an undercover agent or informant in a program under circumstances which would otherwise be prohibited under § 2.19.

(b) *Notice.* An order under this section may be granted without notice where the criminal conduct for the investigation of which it is granted is believed to be carried on by the program director or by any employee or agent of the program with the knowledge of the program director or under such circumstances that in the exercise of reasonable care the program director should know of such conduct. Under any other circumstances, an order under this section may be granted only after the program director has been afforded notice and opportunity for hearing.

(c) *Criteria.* An order under this section may be granted only where there is reason to believe that a program or any principal, agent, or employee thereof is engaged in serious criminal misconduct, and that other means of securing evidence of such criminal misconduct are not available or would not be effective.

(d) *Scope.* An order granted pursuant to this section may authorize the use by the applicant of an undercover agent or informant, either as a patient or as an employee, of the program in question.

(e) *Time periods.* An order under this section may not authorize the use of an undercover agent for an initial period exceeding 60 days. At any time prior to the expiration of such 60-day period, the applicant may apply for an order extending such period for an additional period not to exceed 60 days, but in no event may the use of an undercover agent in any program be cuthorized for more than 180 days in any period of 12 consecutive months.

(f) *Duty of agent.* Except to the extent expressly authorized in an order under this section, which shall be limited to disclosure of information directly related to the purpose for which the order is granted, an undercover agent or informant shall for the purposes of this part be deemed an agent of the program within which he is acting as such, and as such shall be subject to all of the prohibitions of this part applicable to disclosures of any information which he may acquire.

§ 2.67–1 Undercover agents and informants—Basis and purpose.

The legal rationale underlying this section has been set forth in § 2.19–1. It is expected that this section will find its principal and perhaps its exclusive application in the area of drug law enforcement. Experience has demonstrated that medical personnel, no matter how credentialed, can engage in the illicit sale of drugs on a large scale, and that the use of undecover agents and informants is normally the only effective means of securing evidence sufficient to support a successful prosecution.

[FR Doc.75-17169 Filed 6-27-75;9:38 am]

Title 21—Food and Drugs

CHAPTER III—SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

PART 1401—CONFIDENTIALITY OF DRUG ABUSE PATIENT RECORDS

Revocation of Part

On May 9, 1975, there was published in the FEDERAL REGISTER (40 FR 20542) a notice of proposed rulemaking proposing the revocation of Part 1401 of Title 21 of the Code of Federal Regulations by reason of the proposed incorporation of its subject matter in a new Part 2 of Title 42 of the Code of Federal Regulations.

Interested persons were invited to submit written comments, views, or arguments with respect to the proposed revocation, within 30 days of the date of publication of that notice. None were received, except to the extent that they were implicit in those submitted on the proposed new Part 2 of Title 42 of the Code of Federal Regulations, which were duly considered.

Accordingly, pursuant to the authority of section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended by Pub. L. 93-282 (21 U.S.C. 1175), and under the authority delegated to the General Counsel (39 FR 17901, May 21, 1974), Part 1401 of Title 21 of the Code of Federal Regulations is revoked, effective August 1, 1975.

Dated: June 25, 1975.

GRASTY CREWS, II,
General Counsel, Special Action Office for Drug Abuse Prevention.

[FR Doc.75-17170 Filed 6-27-75;9:38 am]

MODULE 7: COMMUNITY ORGANIZATION

MODULE 7: COMMUNITY ORGANIZATION

Focus, Objectives and Resources

FOCUS

This module is designed to surface salient aspects of working within a community. It provides both didactic and laboratory experience in working with others on an organizational basis. Features include a negotiations lab, staging of interviews and methods for approaching boards and committees.

While the material will be presented on the principle and generic skill level, applications to the program level will be evident as well as specifically identified. Working on the generic level, however, allows individuals to see applications of the material to other aspects of their lives.

There is a consistent need for the counselor to have available a wide variety of resources as either supplements or alternatives to the service he/she is providing to the client. Methods for identifying and approaching possible resources and reviewed and the concepts of availability, accessability and acceptability of resources are discussed.

Each participant will have the opportunity to develop an action plan for change in his/her own program based on the community organization principles previously presented.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- Name three aspects of physical staging which can be used advantageously.
- Cite two positive uses of language adaption.
- Cite two negative aspects of poor language use.
- Identify procedures for working with Boards and Committees which increase the probability for successful negotiations.
- State the major qualification of a community organizer.
- Develop an action plan for change in his/her own program.
- Describe two considerations in approaching potential resources to better insure cooperation.
- Explain the importance of using resources that are available, accessable and acceptable to the client.

RESOURCES REQUIRED

The activities in this module will require:

- A trainer

MODULE 7: COMMUNITY ORGANIZATION

Learning Activities Schedule

Activity 1
1 1/2 Hours

Trainer Presentation

This activity is a review of the historical development uses of community work, highlighting the movement toward community development activities. Throughout this presentation, the principles of cooperation will be highlighted and contrasted with confrontation techniques. During this presentation the trainer will describe the proper use of resources, how to identify them and how to approach them to better insure their cooperation.

The role of the individual in changing community opinion or generating community activity will be stressed. Participants will be taught the importance of finding areas of agreement rather than highlighting areas of disagreement.

RESOURCES REQUIRED

- A trainer
- A large room
- A flip chart and felt tip pens
- A copy of the two resource papers for each participant

Activity 2
2 Hours

Negotiations Laboratory

In this activity, the training community will participate in a laboratory experience in staging and negotiating. (An optional method, which may be time-saving, is for the staff members to role play staging and negotiating situations.) The principles of effective self-presentation will be reviewed and participants will have the opportunity to take part in performing and evaluating negotion sessions.

RESOURCES REQUIRED

- A trainer
- A large room with flexible seating
- A desk or suitable table
- A copy of the resource paper "Basic Principles of Community Change," for each participant

Activity 3
1 1/2 Hours

Individual Program Action Plan

Each participant will develop and write-out his/her own action plan for change to be implemented in his/her own program on return from this training. The community organization procedures outlined in Activity 1 of this module are to be used as a guideline. Each trainee will share his/her written (step by step) action plan with members of a small group of six-eight persons, who will critique it according to the guidelines noted above.

RESOURCES REQUIRED

- A facilitator for each group of six-eight persons
- A small room for each group of six-eight persons
- Paper and pencils for each participant

Trainer Guidelines

Activity 1
1 1/2 Hours

This presentation should be spirited and fast moving. the material, expecially through the use of personal examples and anecdotes, lends itself well to humor which is an excellent teaching vehicle. The following is a list of topics which can be used in this activity:

1) The historical movement from community organization in a confrontative mode to the use of community development techniques.

2) The need for community workers to be able to accomplish community goals while they themselves remain anonymous. Tell the participants that the most important qualification of the community worker is that when the job is done, no one will remember his/her name.

3) The varied uses of language including the positive and negative use of "loaded" words, i.e. words that have connotations and emotional overhead and thus have to be carefully managed.

4) The necessity of finding areas of agreement and assiduously avoiding confrontation when negotiating, except in those cases where confrontation is the only recourse and the issue is important enough to justify it. Remember, wrestling concessions from an organization precludes future pacific negotiation in most every instance. The issue must be important enough to justify this or the cost is too high.

5) Techniques for dealing with Boards and Committees. Stress the importance of full preparation with written handouts for these occasions, including prices, logistics, etc., if you want your motion or program voted on.

6) The need for listening to others, especially with respect to #4.

7) Saying no more than is necessary to make the "sale." Permission to undertake an activity or agreement to work together is just that. It

should not be belabored with all the "inherefores" and "howevers." A sale is a sale.

(8) The need to be flexible and interpret activities in terms that they can be 'heard" by those you are negotiating with. History is full of people who have been impaled on their principles because they would not compromise in the least. We have not heard of most of them. Being totally bound to a course of action may result in achieving nothing when flexibility may have resulted in achieving something. A portion of the pie is better than no pie at all.

During this presentation, the proper use of resource persons, how to identify them and how to approach them to insure their cooperation, will be outlined.

Activity 2
2 Hours

Using the handout entitled "Basic Principles of Community Change" (included), conduct a negotiations lab. Select an issue for role playing and ask participants to take part. Explain their roles to them privately, but give the general setting to the entire community. Ask the rest of the participants to take careful discussion notes during the negotiations, particularly noting the points made in the previous presentation and in the trainer introduction to the lab on staging.

After the role play and discussion, repeat the role play, altering slightly the roles of the players as well as the players themselves. Some situations which might be used are:

(1) A woman factory worker, who finds out that females are paid less than males in similar jobs, taking her grievance to the personnel manager (male). The tenor of the manager's responses can be altered from one role play to another.

(2) A mental health worker who wants to run a values clarification program in the elementary school, introducing the concept to the Superintendent of Schools (whose role may be set up or varied as needed).

(3) A substance abuse counselor trying to get the Program Director to make some changes in program policy or procedures. (The specifics should be evolved at the time, according to their relevancy to the "counselor.")

Activity 3
1 1/2 Hours

In helping the participants write their action plans for program change, each facilitator should emphasize that although the several outcomes of the steps in the plan are not, at this point, predictable --- this lack of predictability should not be used for avoiding the development of the complete plan. Rather the participants should be encouraged to outline the several alternative possibilities and to specify:

(1) who of the core group will perform the designated tasks (2) who outside the core group will be dealt with (3) the issues that will (may) be involved and (4) the pitfalls that may be encountered with contingency plans for dealing with them. Each step of the plan should be so organized as a sub-unit of the whole.

BASIC PRINCIPLES OF COMMUNITY CHANGE

Stan DeKemper

Division of Addiction Services
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BASIC PRINCIPLES OF COMMUNITY CHANGE

A critical factor in the successful rehabilitation of a substance abusing client is the degree to which a counselor's efforts are complimented by his program and by his community. Often counselors spend significant portions of their work time attempting to offset a program structure or program policies which hinder the therapeutic progress of a client. Or perhaps the resources in the community are fragmented and don't work together. If the resources in the community are fragmented, then the counselor is forced to "do it all" himself or become quite frustrated. Usually, the counselor becomes frustrated and allocates considerable blocks of time to talking about program reporting requirements, the lack of community acceptance or support, and his program director's or board's insensitivity to client needs.

Commonplace is the counselor who focuses only on "counseling" his client and not on maximizing his own effectiveness by mobilizing community resources, altering program design and developing community awareness of his client's plight. "Ain't it awful" is this counselor's battle cry. The mark of an effective counselor is his success at being a change agent within his program and community as well as with a client.

How does a counselor go about influencing his program and/or community to be supportive of his work? To increase the probability of change occuring within a program or a community, a counselor needs to utilize the concepts of community change and of negotiation.

COMMUNITY CHANGE

In order to understand the process of community change, a brief review of the historical development of community organizing is helpful. The labor union movements in the 1930's were the beginning of a wave of social change which dominated the United States until 1970. The labor movement was followed by the civil rights push for blacks, for women, for gays and for other minority groups. All these movements involved uniting a group of people around a common issue so that the issue could be resolved. Characteristic of these organizing efforts was a win-lose philosophy. This win-lose approach is epitomized by the tactics and language used by the black movement of the '50's and '60's. Sit-ins, protest marches, the black power clenched fist demands and television coverage were some of the tactics used while the language of the movement was polarized and actually divided people. "If you're not part of the solution, you're part of the problem." was a popular phrase and is symbolic of the polarized, right-wrong morality which characterized most of win-lose organizing. Visibility for such organizing efforts was generally high with leaders such as Dr. Martin Luther King seen in public places, on T.V., on the radio or on the frong page of the newspapers. Such visibility combined with polarized language and tactics created an atmosphere of attacks and hostility. While win-lose organizing won battles, it often lost the war. Attacking the mayor of city publically never endeared the mayor to the group who attacked him. Sure, the community group may have gotten their demand met for re-paving their street but the mayor would not give them cooperation in the future unless they overpowered him again, which is less likely the second time around.

Below is a chart which compares the concepts of win-lose organizing and those of win-win organizing:

APPROACHES TO COMMUNITY ORGANIZING

Win-Lose		Win-Win
Power concedes nothing	- Philosophy -	Appeal to individual interests
Moral Rights	- Focus -	Satisfy needs
Polarized	- Language -	common
Us	- Recognition-	others
high	- Visibility -	hidden
Attack, hostility	- Atmosphere -	warm, sharing
Negatively defined	- Future -	open

Since the 60's, community organizing efforts have generally begun to move from a win-lose posture to that of win-win. Although there have been enormous "victories" through using win-lose approaches in organizing, win-lose is now viewed as a last resort because of its divisive power.

In win-win approach, the organizer appeals to the self-interests of everyone involved. He appeals to the ego needs of management as well as line staff. The organizer focuses on satisfying needs of the community or agency. A win-win organizer focuses on needs which the people agree on rather than over what they disagree. If the approval of the school superintendent is needed for implementation of a substance abuse education program, you would focus on your agreement of the need for education rather than your disagreement over whether drug and alcohol addiction are diseases or merely symptomatic behavior. The language used in such an encounter would be language which is acceptable to the superintendent. If he does not like the word "sensitivity," the win-win organizer would use words like "identifying individual strengths and weaknesses" so that the superintendent is not alienated.

When the T.V. cameras roll, it is the superintendent who is filmed, not the organizer. The win-win organizer has low visibility. The most important characterstic of a win-win organizer is that when the job is done, everybody else involved thinks they did it. The atmosphere which surrounds such organizing is warm and everyone involved participates in the decision making. The future of such an organizer is always open. The school superintendent will call on the organizer again when he has a need because the organizer makes things happen while the superintendent gets the recognition.

In implementing either a win-win or a win-lose approach to community organizing, an organizer should utilize a systematic methodology to achieve the change desired. Often an organizer will become so excited in the heat of the moment, that strategy and action supercede the preparation and clear-headed analysis vital for any successful change effort. How often have you witnessed yourself or a co-worker run to the program director or school principal with change in mind only to be defused with "thats the way things are" or "they really arent' that bad" response.

To realistically facilitate change within an agency or community, it is essential that an organizer systematically follow a methodology. The following six-step organizing procedure is a process that focuses on people as well as facts and problem solutions.

Define Community

A community is a group of people which share some common characterstics. A community may be religious (Jewish) geographical (Northside Indianapolis), racial (black) or an agency (the South Bend Detoxification Program). It is imperative to define specifically which community is the target population for organizing change.

Assess Community

A thorough assessment should be made of the community targeted for change. The assessment should give the organizer a wholistic picture of the community: how the members of the community view their community as well as what is actually there. Many times there will be significant discrepancies prevent the community from utilizing its resources to solve its problems. Listed below are elements of a community which should be explored during the assessment process.

Definition of Elements

History. History may be thought of as the "selective recording and interpretation of past events." That is, you never learn about all of the previous activities in the life of a country or community; the causes and effects of past events are usually explained in one way or another.

In reviewing the history of the community, we are concerned with:

(1) its official and more or less "objective" history as it may be given in public documents, etc., and
(2) its traditional or folk history as recounted by its residents.

A preliminary study of the history of the community provides:

-background information needed to understand its present position and problems.
-a widely acceptable means to show your respect for its people and their way of life.
-an opportunity to meet a number of its key residents.
-many insights into conflicting values, factions, etc.

Space Relations. Through this element we look at:

(1) the internal relations within the community, its geographic area, and the disposition of its people, industry, social activities, etc.;
(2) the external relations of the community with other communities in the vicinity and with the regional and national capitals,

including the means of communication and transportation and the distances and times involved for each;
(3) the number and kinds of links that exist between this community and others through trade, marriage etc.

Resources. The resources of a community are any aspects of its total environment which its people may use to meet their individual and shared needs. Such resources include the services available from government and private agencies. In assessing resources, the following subdivisions may be useful:

-- human -- the number of people and their capabilities, with allowances made for age, disease, malnutrition, etc.;
-- man-made -- such items as roads, communication media, etc.;
-- natural -- land, water, minerals, forests, sources of energy, etc.

Technology. Technology consists of the tools, skills, and techniques used by people ot exploit their environment. Through this element we examine the methods used by people to make a living from their resources, the kinds of know-how they employ to solve problems, and the ways in which they adapt to their circumstances. (Technology is thus linked with the available resources, knowledge and beliefs, the goals and norms of the people, and their values and sentiments.)

Knowledge and Beliefs. This element covers what is known and thought about the world, and life in it, and is thus related to technology, the use of resources and goals.

In belief there is an aspect of personal conviction which is absent from mere knowledge. It is therefore easier to change knowledge, on the whole, than to affect belief. On the other hand, a program linked to people's beliefs has a firmer foundation than one which is based upon items of information which they know, but do not particularly care about. Beliefs are linked with values and sentiments.

Values and Sentiments. *Values* are essentially "ideals of the desirable" which are held by individuals; many values are shared by most of the people in the community and thus form the basis for predictable patterns of behavior.

Sentiments consist largely of what people feel about certain issues. Both values and sentiments are very resistant to change. Often they form the basis for community-wide action, whether planned or unplanned. Despite the difficulties, it is crucial to identify the principal values and sentiments in the community since they form the foundation of goals, norms, social rank, sanctions, and other elements.

Goals and Felt Needs. These are the specific and concrete targets which people set for themselves; they are clearly related to the people's values and sentiments and also to their knowledge and beliefs. As with those elements, some goals will be shared by most of the people in the community, others will be limited to certain subgroups, and others will be specific to individuals. A widely shared goal may become the focus for an early development project.

Goals may also be thought of as felt needs. Of the many needs which may be observed in a community, people will be aware of some of them; these are their felt needs, in contrast to other needs which they do not recognize.

Norms. Norms are the standards of what is right or wrong, good or bad, appropriate or inappropriate in social life in the community. They form the "rules of the game" which indicate acceptable standards of conduct for every social situation. Norms are apecific recommendations for behavior derived, like goals, from the values and sentiments of the people. Norms are enforced by various forms of social pressure (see Sanctions) in the community.

Positions and Roles. The positions in a community range from formally elected offices through to the informal position of "best friend." The set of behavior patterns associated with each position is termed a *role*. Usually, an individual holds a number of positions, (i.e., one man may be a town councilor, a farmer, a husband, a father and a son, to name just a few). His behavior in any given situation depends upon which position he sees himself in, and what cluster of behaviors he associates with that position.

To give an example, you may be baffled when a man agrees with you on one occasion and then disagrees later. In the first case, he may have agreed with you in his capacity as village leader, but in the second he spoke as a highly conservative head of his family. If you were assigned to a village by a government health agency, you might be rejected initially by the villagers as a potential tax assessor. But if you then took on some more acceptable positions (friend of youth, musician, gardener) and acted out these roles effectively, you and your real work might later bacome widely accepted.

Power, Leadership, and Influence. *Power* describes the ability of one person to control others. *Leadership* involves the ability to help a group to make decisions and to act on them; it may include organizing people formally or informally. Remember that a leader is one who has followers -- not all who act and sound like leaders actually have followers. Leadership capacity is indicated by the number and stability of a leader's following. Most leaders lead from in front; many other effective leaders prefer to lead from behind, quietly and almost unnoticed -- don't overlook them! *Influence* is the ability to affect the behavior of others, often without their being fully aware of it.

Note that while some people possess these capacities in most spheres of community life, others are effective in only one area; e.g., a man may be a power figure, a leader or influential in matters of agriculture but not in social or political life.

Social Rank. Social rank describes the standing that a person or group has in the community; it may depend largely on one's family and inherited characteristics, or it may rest upon the individual's personal achievements. The factors which determine who "rates" depend a good deal on the values which predominate in the pattern considered.

Sanctions. These are the rewards and punishments which induce an individual to retain the goals and norms of the group. They help to assure the preservation of the group and its way of life by encouraging support for its values and sentiments, positions and roles.

Develop Core Group

Once the community has been assessed, a core group of community members should be formed who have interest in change and, hopefully, some influence in their community. These members should have been identified during the assessment. The organizer's task during this step is to develop healthy win-win dynamics among this group.

Set Priorities

From the assessment a huge amount of data has been generated. The organizer's function during this step is to aide core group members in analyzing the assessment data and determining the priorities for change. Care should be taken to set prioriteis which are attainable.

Develop Strategy

A plan of action or strategy should be developed by the core group which delineates the priority objectives, what tasks will be necessary to achieve the objectives, a timetable and an assignment of responsibilities for task accomplishment to individual group members. Included in the strategy development may be practice for core group members in how they will approach other members of the community during negotiations.

Action-Reflection

After a strategy has been developed to accomplish priority objectives, the strategy is then executed. It is essential that after every major task is carried out, that task should be reflected upon. Often a core group will need to change their strategy based upon outcomes

If these six steps of community are adhered to and if the organizer is aware of his stance regarding a win-win posture, the probability of his influencing meaningful change will be greatly enhanced.

NEGOTIATION

One aspect of community organizing which deserves special attention is the art of negotiation. Negotiation is generally associated with win-win approach to change. The term itself implies a solution to a porblem which is mutually satisfying to all parties involved in the problem.

The primary goal of a negotiator should be to achieve his desired outcome through a consensus decision of the people involved in the negotiation. A successful negotiator needs to have all people involved in the negotiations invested in the outcome in order to prevent sabatage at a later date in his relationship with these people.

One of the most important aspects of fruitful negotiation is the effective self-presentation of the negotiator. There are three basic areas of concern for effective self-presentation during negotiations.

Preparation

A negotiator should always diagnose the problem or conflict which he desires to resolve. He should analyze the forces which push for change and those which restrain change. An understanding of these forces will aid in visualizing what are the assets for change and what are the liabilities restraining change.

Once these forces are understood, the negotiator can identify what areas of agreement to highlight during negotiations. A written document should always be prepared prior to negotiation which stress such areas of agreement and contain the outcomes desired by the negotiator. Such a document should be brief or at least contain a summary paper.

Win-Win Philosophy

In approaching negotiating, an organizer should be in a head set of wanting to listen to and satisfy the interests and needs of the other parties involved.

Staging

One of the most crucial issues of negotiation is the physical presentation of self during negotiations. Seating arrangements, body postures and body movements are elements of staging which communicate very powerful messages to participants of a negotiating process. Sophisticated negotiators often spend enormous blocks fo time deciding who will sit where. The Paris Peace talks on Vietnam during the early 1970's spent months negotiating over who would sit where around what kind of table. Most people who you will negotiate with will not be that sophisticated. In fact, if you understand the dynamics of staging and are confident, you should be able to control the staging process.

Below are some general guidelines for staging negotiations for a one to one basis and for one to group staging.

STAGING
(1-1)

1. Come in close-
   shake hands - smile -
   or touch - smile -

2. Back off and when possible choose your site carefully
   Take a
   - (a) center position
   - (b) high position
   - (c) front position

3. When site is forced
   - (a) rearrange chair before you sit down - (harder with a sofa) ESTABLISH YOUR OWN SPACE

   - (b) SIT BACK - you are comfortable

4. Tell 'em what you're gonna say
   SAY IT
   Tell 'em you said it

5. Terminate quickly - slightly abruptly but not hastily
   Stand Up - say it was good talking to you

   LEAVE - DON'T LINGER - DO NOT ALLOW THIS KIND OF INCOUTER TO SHIFT TO AN EMOTIONAL - OR SOCIAL INTERACTION AT ITS TERMINATION - SO GET OUT WHILE YOU'RE AHEAD OR BEHIND.

STAGING
(Groups)

1. Walk into room calmly and purposefully

2. Cross the front of the room

3. Choose site carefully -
   again - front
   center
   high

4. SIT BACK

5. Smile to those around you - YOU ARE COMFORTABLE!

In concluding, I would encourage you to review the concepts of community/program change and of negotiation presented in this paper and apply them to your own situation and needs.

I would also like to express appreciation to Tom Oaks, V.C. League, and Joel Warner for their inspiration and ideas.

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WIN/LOSE SITUATIONS*

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* Reprinted from *The 1973 Annual Handbook for Group Facilitators*, J. William Pfeiffer and John E. Jones, Editors. La Jolla, California: University Associates Publishers, Inc. 1973.

WIN/LOSE SITUATIONS

Win/lose situations pervade our culture. In the law courts we use the adversary system. Political parties strive to win elections and to win points in legislatures. Debates are common at schools, universities, and in the media. The put-down is generally regarded as wit. Competing with and defeating an opponent is the most widely publicized aspect of a good deal of our sports and recreation.

The language of business, politics, and even education is dotted with win/lose terms. One "wins" a promotion, "beats" the competition, buys a lubricant to obtain "the racer's edge" for his auto. Students strive to "top the class" or "outsmart" the teacher. Although we do recognize cooperative effort and collaboration, it seems that we tend to emphasize "healthy" competition.

In an environment that seems to stress winning, it is no wonder that competitive behavior persists where it is not appropriate. Imagine a typical committee meeting to decide on a suitable program for a club. Members interrupt each other to introduce their own ideas. Proposals are made which other members do not even acknowledge. Partnership and even power blocs are formed to support one program against proponents of another. When members of such a committee are enabled to analyze the operation of the group, they commonly agree that they were not listening to each other because they were thinking of ways to state a case or to counter the proposal of someone else. They were interrupting to get a point out before the speaker clinched the sale of his idea. In these ways they were acting as competing individuals rather than a collaborating group. They had started to reach the best decision regarding the program, but had slipped into a win/lose contest. Very often the original purpose is completely overshadowed by the struggle to win. This is a common failing of committees.

Group meetings are not the only sphere in which win/lose can arise. Visualize a consultant discussing a client's problem. For any of a number of reasons, the client may perceive his helpful suggestions not as the consultant intends but as criticism of the client's methods, or whatever. As a result the client might also feel that he was in competition with the consultant. The contest would revolve around whose methods were more effective or who could do the job better. Instead of listening to the recommendations, the client would be trying to shoot them down. For his part, the consultant would be concentrating on defending his expertise. When a consultant and client are locked in a win/lose match, the chances are very small that the consultant's advice will be used.

Win/lose contests can also develop in an organization. Individuals may strive for dominant position. Battles can rage discreetly, and otherwise, between departments. For example, a planning department might develop a new assembly procedure. When it is introduced to the assembly department, the workers might resent it and lock horns with planners. It is easy to interpret the situation in win/lose terms. The planners are showing that they know more and can design a procedure better than the men on the job. If the new procedure works well, the planners "win." On the other hand, if the innovation does not improve production, the planners "lose," and, in a sense, the assemblers "win" because their normal operation proved superior. Seen in this light, it should be expected that the workers will not be committed to giving the innovation a fair trial. In extreme cases, they may even sabotage it "to show those theoretical snobs in Planning." In fact all efforts to plan for others are plagued by win/lose traps. In some companies and institutions internal win/lose rivalries absorb more effort than the main production or service.

POTENTIAL RESULTS OF WIN/LOSE

Although there are obviously some instances where win/lose is a positive factor, it is generally destructive. Win/lose is too often poison to interpersonal relations and organizational effectiveness. Suppose a husband loses an argument with his wife so that they go dancing instead of to a horse race. He can retaliate by being sullen or obnoxious. He has turned a win/lose situation into an ordeal where both partners are miserable. Often win/lose "victories" become losses for both parties. This has been termed a "lose/lose" result.

Some of the negative results of win/lose have been shown in the examples already given. Here is a list of fourteen problems which may arise from win/lose confrontations. They are not in any particular order, nor are they comprehensive.

Win/lose may:

1. divert time and energy from the main issues
2. delay decisions
3. create deadlocks
4. drive unaggressive committee members to the sidelines
5. interfere with listening
6. obstruct exploration of more alternatives
7. decrease or destroy sensitivity
8. cause members to drop out or resign from committees
9. arouse anger that disrupts a meeting
10. interfere with empathy
11. leave losers resentful
12. incline underdogs to sabotage
13. provoke personal abuse
14. cause defensiveness

ADJUSTING WIN/LOSE

Since win/lose events will undoubtedly be experienced by us often in the course of time, it is important to know how to cope with them. Since the predominant trend of win/lose contests is toward lose/lose outcomes, it becomes a matter of redirecting them toward "win/win" results. In a "win/win" result everyone comes out on top.

It is extremely difficult for one person alone to reorient a win/lose. You are likely to be treated as a third party in the scrap, or you may have both adversaries turn on you. Although it would be ideal to have all parties committed to avoid win/lose, the efforts of a significant segment of a group can usually be effective. In a one-to-one conflict, one of the parties can often turn off a contest. It takes two to fight. The more persons in a win/lose situation who recognize the dangers in such a struggle and want to adjust the situation, the more likely they will succeed. Supposing such a subgroup exists in a committee, what can they do to help?

Some Means of Adjustment

1. Have clear goals, understood and agreed upon. Use the goals to test whether issues are relevant or not.
2. Be on the lookout for win/lose. It can develop subtly. If you feel under attack, or feel yourself lining up support, you are likely in a win/lose.
3. Listen empathetically to others. Stop yourself from working on counter-arguments while another person is speaking. Take the risk of being persuaded. Try the other person's reasoning on for size.
4. Avoid absolute statements that leave no room for modification. "I think this is the way..." is better than "This is THE ONLY way..."
5. If you are planning for others, provide some means for their involvement. The doers should feel that they can have influence on decisions that affect them.
6. Try to make decisions by consensus rather than by victory of the majority.
7. Test to see that trade-offs and compromises are truly accepted by all.
8. Draw a continuum line and have members place themselves on it regarding the issue. It often occurs that the different "sides" are not far apart.

9. Be alert to selling or winning strategies in others, and avoid using them yourself. "Any intelligent person can see the advantages..." would be a danger signal.

Again this list is not exhaustive, but may provide a beginning toward more productive relationships. The key idea in adjusting win/lose is to strive for what is *best for all* rather than trying to *get your way*.

DECISION MAKING

by

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Prepared

by

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DECISION MAKING

Every group, to achieve its goal, is constantly involved in making decisions-- little decisions, easy decisions, hard decisions, right decisions, wrong decisions, but always decisions, decisions, decisions.

Decision-making is thus a continuing pattern of relationships among members of a group, a pattern over which every individual member has significant influence. It is amazing the effect a bit of information here, a loud objection there, an expression of approval or hostility, envy or admiration, contempt or condescension can have on an impending decision.

So there is little wonder that group after group has difficulty making decisions. Some become paralyzed when confronted with a decision; some argue interminably over a minor point; others rush into a vote, only to reverse their decision later on or to fail in carrying it out; others appoint a committee or look for a saviour (the chairman) to save them from having to decide.

DIFFICULTIES IN DECISION-MAKING

Most of the difficulties encountered by the group in making decisions center around one or another of the following factors.

1. *Fear of Consequences*
   In some groups the *possible outcome* of an impending decision may bring divisions and disagreements. Frank acknowledgement of these fears often suggests how they can be dealt with effectively.

2. *Conflicting Loyalties*
   Multiple membership in a number of groups frequently leads to *divided loyalties* among group members. An atmosphere in which it is possible for these conflicts to be brought out into the open without threat to the individual is a great help in their resolution.

3. *Interpersonal Conflict*
   In groups of any size personal differences occur which provoke feelings of affection or of antipathy among members and which inhibit sound decision-making. Often another member who is not involved in the interpersonal conflict can bring the real problem into bolder relief.

4. *Methodological Blundering*
   A group may be so *bound by rigid procedures* that there is little chance for free expression of differences. Or a group may allow itself to *substitute personal opinion for adequate data.* Or a group may approach the decision-making process without testing for consensus.

5. *Inadequate Leadership*
A designated leader falls short of his responsibilities when he restricts the expression of opinion or discussion of issues, when he fails to provide assistance in selecting appropriate methods for decision-making and when he is insensitive to the factors causing difficulty - the motivations and standards of his group.

AREAS OF DECISION-MAKING

Six basic problem areas in the movement of a group toward its goal can be identified. Of course, no group moves directly through the six problem areas in a given order.

1. *Problem Area #1:*
(What is our situation?)
Who are we? Where are we? What is our common ground? What are the limits within which we must work? Who or what brought us together? Until a group recognizes its actual present situation, by gathering the data about that situation, any attempt to suggest goals is premature.

2. *Problem Area #2:*
(What is our destination?)
Where do we want to go? What choices are open to us? Until there is general *agreement on the goal,* the group will not move effectively. Members of a group who have not accepted the goal or who have had little voice in choosing it tend to be self-oriented. The greater the share all members have in choosing the goal of a group, the greater will be their willingness to subordinate their immediate personal interests to the common interests of the group. The settling of a goal is also necessarily tentative and must be re-examined from time to time in order to test its adequacy.

3. *Problem Area #3:*
(How do we get there?)
What procedures are called for? What resources are needed? Members become more involved in the functions of *initiating, clarifying, expediting,* and *testing* for consensus as a group goes about determining the best ways and means, routes and methods, necessary to get underway.

4. *Problem Area #4:*
(How free are we to move?)
If a group is to be creative, individuals must be free to act, to offer insights, to test ideas, to make contributions, to share the leadership without fear of inadequacy. Such functions as *encouraging, harmonizing,* and *supporting*

are needed to maintain an atmosphere of freedom.

5. *Problem Area #5:*
   (Where are we now?)
   Where are we in the process of settling all the other problems? Are we going in the right direction? How far have we gotten? Do we know where we are? Do we need to change our goal or our procedure? Is everyone still on board? *From time to time a group must make a progress report to itself.* Many a group has failed to reach its goal because it assumed everyone knew where the group was when actually confusion reigned.

6. *Problem Area #6:*
   (Where have we arrived?)
   Have we reached our goal? Where are we finally in terms of our achievement? It may not be the original goal, but is it satisfactory? A group sees its goal through the eyes of its members and their need to arrive at some goal.

CATEGORIES OF DECISIONS

In moving toward its goal and in solving its problems, a group makes countless decisions, usually in a variety of ways.

1. *Plops*
   A decision *suggested* by an individual to which there is *no response.* Plopping often occurs in a new group confronted by a complexity of problems, in a group where a number of the members have fairly equal status, when a member is overly aggressive, when a member has difficulty in articulating his suggestions.

2. *Self-authorized Decision*
   A decision by an individual who assumes authority to do so. When such a decision is proposed, the group as a whole often finds it easier to accept than reject, even though some individuals may not be in agreement. The *decision* is *thus by default.*

3. *Hand Clasping*
   A decision made by two members of the group joining forces. Such a decision emerges so suddenly that it catches the other members of the group off guard and at the same time presents them with another problem (how to deal with the two people at the same time).

4. *Topic-jumping*
   A *decision cut short* by the inappropriate intrusion of another topic. Topic jumping confuses the issue confronting the group and thus changes the nature of the decision.

5. *The Clique*
   A decision agreed upon in advance by several members of the group. Cliques are present in almost every group and their prearranged decision may be very good. But the effect of collusion is to *destroy group cohesiveness* and a sense of trust among group members.

6. *Majority Rule*
   A decision made by some form of voting. The traditional procedure of taking a vote often seems to be the only way in which to reach a decision under the given circumstances. *Nonetheless the minority may remain against* the decision despite the vote and *therefore not likely to act on it.*

7. *Does Anyone Disagree?*
   A decision made by pressure not to disagree. When confronted by such a question, several persons who really disagree strongly or who have not had opportunity to express their opinion on the issue, may show real *reluctance to voice opposition with no apparent support.*

8. *We All Agree, Don't We?*
   A decision made by pressure to agree. Again, as when under pressure, persons who really disagree or who have not had an opportunity to express their opinion would probably be reluctant to voice opposition alone.

9. *Unanimity*
   A decision made by an overt and unanimous consent. The pressure to conform may be strong enough to win apparent 100% agreement. But even a majority of the members may inwardly disagree and may consequently fail to act in support of the decision.

10. *Consensus*
    A decision made after allowing all aspects of the issue, both positive and negative, to be put forth to the degree that everyone openly agrees it is probably the best decision. Dissenters, once they have been clearly heard, will usually go along with a decision and act

upon it with commitment, at least to the point of provision for later assessment.

STEPS IN DECISION-MAKING

Effective decision-making by a group on the basis of consensus is both realistic and possible. But it is not easy. There are five basic steps which a group can take in arriving at a decision with some assurance that it represents the mind of *the group as a whole and that it will be acted upon.* It is well also to be aware of what might help a particular step, of what might block it, and of what might cause its omission.

1. *Defining the Problem*
   The process of defining the problem, *sharpening the focus* so that the issue is clear, internalizing its various *implications,* clarifying it and elaborating on it.
   a. *omission:* a standing committee that is reappointed year after year but that never reviews its purpose.
   b. *blocks:* the assumption that the problem is clear: over-abstraction of the problem; the assumption that the problem is relevant.
   c. *helps:* a problem census; small groups; general discussion.

2. *Suggesting Alternative Solutions*
   The process of getting ideas on the various *alternative* solutions to the problem from all *members.*
   a. *ommission:* a chairman who limits a group to working on the implications of a solution he has already decided upon.
   b. *blocks:* lack of data; lack of experience; group size; member threat; overformality; inadequate maintenance functions; polarizing on a particular solution.
   c. *helps:* brainstorming; additional data; subgroup work; a climate of freedom; periods of silence.

3. *Testing the Alternatives*
   The process of examining the alternatives in the light of all available data, percious experience, possible consequences, relevance to the problem, and members' attitudes.
   a. *omission:* the prestige or influence of the chairman or of some other member which prevents the group

from putting his alternative under real scrutiny.

b. *blocks:* lack of data; premature voting; overprotection of ideas by individual members; inadequate maintenance function.

c. *helps:* provisional try attitude, collaborative rather than competitive; group seeking to make each alternative really attractive.

4. *Choosing Among Alternatives*
The process of reaching a decision by choosing one of the alternatives, or a combination of alternatives, that will provide a solution to the problem defined.

   a. *omission:* a committee that goes on and on and on - exploring the ifs, ands, and buts, ad infinitum - but never arrives at a decision.

   b. *blocks:* inadequate testing; lack of clarity regarding the problem; premature voting; no testing for consensus; identification of ideas with persons.

   c. *helps:* expression of feelings by all members; maintenance of an agenda for future reference; summarizing of discussion; testing for consensus.

5. *Planning For Action*
The process of *making detailed plans for carrying out the decision* by examining the implications of the choice and testing the relevance of proposed action. It should be noted that the planning step sometimes results in re-thinking the decision and *returning to one or another prior step* in the decision-making process.

   a. *omission:* failure to assign responsibility for implementation of the decision once it has been made.

   b. *blocks:* failure to reach consensus; failure to explore adequately the implications of proposed action; assigment of total responsibility for implementation to one person.

   c. *helps:* feedback; observer reports; evaluation; post meeting reaction reports; review of data; climate of freedom.

CONDITIONS RELEVANT TO GROUP DECISION-MAKING

There are many instances where, due to the pressure of time, the type of decision, or the area of responsibility, an individual and not a group may most appropriately make a decision. There are, however, certain conditions that make decision-making by a group the most appropriate means of solving a particular problem:

- when *various points of view* and opinions are needed.
- when the *group is directly affected* by the decision.
- when the *group must carry out the decision.*
- when the group has learned to work effectively together.
- when the leadership functions are shared.
- when decision-making procedures appropriate to the problem are used.

FACTORS WHICH FACILITATE GROUP DECISION-MAKING

There are certain specific factors that affect any group situation and that serve especially to improve the decision-making process:

- a clear definition of the problem
- a clear understanding of who has *what degree of responsibility* for the decision
- effective means of producing and communicating ideas
- an appropriate size of the group for decision-making
- effective means of testing alternative solutions
- effective means of implementing the decision
- commitment of the designated leader to the group decision-making process
- agreement on the decision-making procedure prior to deliberation on the issue.

MODULE 8: CLOSURE

MODULE 8: CLOSURE

Focus, Objectives & Resources

FOCUS

The closure module brings the training course into perspective by reviewing the flow, design and elements of the training as they were presented. A contextual review of the design and the considerations leading to that design will assist the participants in developing an understanding of the process they have experienced. This will contribute meaning to the experience.

LEARNING OBJECTIVES

At the conclusion of this module, each participant will be able to:

- o Give evidence of an increase in knowledge on addictions and counseling in terms of the four cognitive training objectives for Unit C (see Training Objectives - Unit C).
- o Give evidence of a statistically significant attitudinal change in two attitudes specified in the Training Objectives - Unit C.
- o Give evidence of assessing client intake data, writing a treatment plan and selecting modes of treatment.
- o Give evidence of developing an action plan for change of his/her program or community.
- o Describe the rationale of the training process for the individual counseling skills training course.
- o Name two ways in which the design of the course allowed for his/her individual needs.

RESOURCES REQUIRED

The activities in this module will require:

- o A lead trainer or cycle manager
- o A large room with flexible seating
- o A flip chart and felt tip pens
- o A copy of the post-test for each participant
- o Four training evaluation feed-back questions on newsprint

MODULE 8: CLOSURE

Learning Activity Schedule

Activity 1
45 Minutes

Briefly explain the purpose of the post-test to measure the group movement for purposes of evaluating the training. Then ask the trainees to respond in writing as honestly and specifically as they can to the following questions about their training experience.

(1) "What did you find least helpful?"

(2) "What did you find most helpful?"

(3) "Give one positive and negative feed-back statement to each member of the staff."

(4) "Any other comment to the staff about the training."

RESOURCES
REQUIRED

- A trainer
- A large room with flexible seating
- A copy of the post-test for each participant
- Four training evaluation feed-back questions on newsprint

Activity 2
30-45 Minutes

Trainer Presentation

The trainer will present an overview of the course, including the elements of design and flow. The pre-design considerations and the philosophical issues which led to the particular course design will be reviewed and discussed.

RESOURCES
REQUIRED

- A lead trainer or cycle manager
- A large room with flexible seating
- A flip chart and felt tip pens

Activity 3
30-45 Minutes

Group Closure

The members of the group will share their feelings and thoughts about the group and about the experiences they have had together. Participants will have the opportunity to make statements about their learning and how it will affect their work.

RESOURCES REQUIRED

- A trainer
- A large room with flexible seating

MODULE 8: CLOSURE

Trainer Guidelines

Activity 1
45 Minutes

Make a short explanation of the post-test emphasizing the need of the staff to know if their training goals have been accomplished and that the test is used to measure group change rather than individual performances.

Activity 2

This is a particularly important piece of the training, as the trainer has the opportunity to turn an ambivalent experience into a positive one by assisting the participants in understanding what they have done and why they have done it. A well-done closure piece can affect the length and amount of impact the training has on the participants.

The training should review "Some Introductory Basics for Group Dynamics" (Joover, Justis and Glenn) and "The Contingencies of Learning and Attitude Formation" (Justis). These are both resource papers in the companion course to this one, "Group Counseling Training Course." In the first article particular attention should be paid to the five-stage growth model and the differences between perceived and actual expertise. This has, naturally, immense implications for training design and it should be explained how group leveling, communication and maintenance functions were built into the design in an attempt to help everyone progress along the five stage growth model. The strength a person gets from bringing the perceived and actual levels of competence together should be noted.

In the second article, "Contingencies," particular attention should be paid to the three aspects of learning, cognitive, affective and behavioral. It should be explained how the design of the program has provided for growth in these three areas. The participants should be charge to continue their development in areas which are appropriate to them.

The participants should see how the design was put together to allow room for everyone to be individuals and work, as far as possible, in a heterogenons group, at a level and on issues which were relevant to them.

Activity 3

Some emotional closure must be brought to the experience and one appropriate to the group should be designed. One option is to bring everyone together in a circle to experience closeness and the opportunity should be given to everyone to make comments as they deem appropriate. Remarks by staff members should be of encouragement and praise to the group and the comments should be short and to the point.

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BASIC SUBSTANCE ABUSE COUNSELOR'S TRAINING COURSE

Individual Counseling Skills
and
Client Management
Resource Manual

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PREFACE

The Division of Addiction Services, Indiana Department of Mental Health, is a combined single state authority for alcohol and drug abuse. Therefore, when feasible, training packages have been developed to train both alcoholism and drug services personnel. The Basic Substance Abuse Counselor's Training Course was designed with this in mind.

Course development began in early 1975 when the Education and Training Branch (ETB) of the Division conducted a training needs assessment of more than 200 alcoholism and drug counselors. The Division of Addiction Services employed the assistance of Social Systems, Inc., to collaborate with the Education and Training Branch staff in the design and initial delivery of this course. During the first four presentations of the course, modifications of training design were made. These were minor revisions that have been incorporated into the Trainer's Manual in its present form.

The course was initially delivered by trainers from Social Systems; staff members from ETB acted as facilitators. During this time, ETB staff members became familiar with the course and were able to assume responsibility for course management and delivery. The Education Training Branch then developed a component to evaluate the training objectives. This component includes the pre/posttest. As of June 1977, nine presentations of the Basic Substance Abuse Counselor's Training Course have been delivered; a total of 220 participants have successfully completed the course.

In cooperation with the State of Indiana, this Resource Manual was developed by the National Drug Abuse Center for Training and Resource Development under the auspices of the National Institute on Drug Abuse. This collection of resource material is designed to accompany the Individual Counseling Skills Trainer's Manual, Units B and C. Unit A, as developed for Indiana, is designed to provide an overview of substance abuse. It is available, revised and updated, from NDAC as Fundamental Facts and Insights.

ACKNOWLEDGEMENTS

This Resource Manual was adapted for use by participants from the Individual Counseling Skills Trainer's Manual. The developers of the course must be given full credit for the training design and resource materials. The course developers, H. Stephen Glenn and Joel Warner, were with Social Systems, Inc., at the time these materials were written. Education and Training Branch staff members who collaborated on course development are Stanley DeKemper, Training Officer; Luz Einsiedel, Training Officer; Michael Ferry, Training Officer; DeRoss Salisbury, Jr., Training Officer; Robert Tyburski, Branch Chief; and Edward Ward, Evaluation Specialist. The resource papers, which appear in both manuals, were reprinted exactly as they appeared in the Trainer's Manual.

At the National Drug Abuse Center, Normandie Kamar, in collaboration with Ann R. Bauman and the staff at ETB, designed this manual for participants to use during the training.

UNIT B : INDIVIDUAL COUNSELING SKILLS

INDIVIDUAL COUNSELING SKILLS
UNIT B

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of Psychology" .147
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Neurotic Behavior" 155
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INTRODUCTION TO UNIT B

The Basic Substance Abuse Counselor's Training Program provides an opportunity for participants to identify and assess the various attitudes, values, and behaviors with which they enter the counseling situation. Through several self-assessment and other activities, they explore the mental, spiritual, and physical aspects of the individual; they identify and examine sociological imprints and the values resulting from these; and they assess their attitudes about themselves and compare these to others' attitudes toward them. Principles of behavior change are identified and examined in terms of their relevance to individual counseling.

Module 1, Introduction and Assessment, is designed to stimulate discussion about individual growth and counseling principles. Participants are encouraged to identify their training needs and expectations.

In *Module 2, The Whole Self,* the discussion focuses on the interrelationships among the three aspects of an individual: the mental, physical, and spiritual. The classical Eastern and Western theories about the individual are compared, contrasted, and examined in terms of their implications for counseling.

Module 3, Free Theatre, is designed to help group members feel closer to one another and to help participants understand the importance of a client's nonverbal expressions.

Module 4, Somatic Awareness, is designed to bring the physical, spiritual, and mental elements of the training into harmony. The activities, such as yoga, meditation, and breathing exercises, are based on Eastern philosophies and practices and on Reichian theories of body processes and their relation to spiritual and mental health.

In *Module 5, Sociological Imprints,* participants examine their sociological imprints: the values and attitudes that are derived from the positive and negative experiences of life. The activities in this module are designed to help participants understand themselves and others and to determine the influence that imprinted values can have on the counseling relationship.

In *Module 6, Principles of Behavior Change in Counseling Situations,* the seven principles of behavior change are identified and their use in counseling is examined. The work of some major therapists and schools of therapy is considered, but no specific counseling techniques are espoused or rejected.

In *Module 7, The Six Selves,* participants will attempt to depict the six aspects of themselves: their physical, emotional, intellectual, spiritual, public, and private selves. Consideration of each aspect will provide a more thorough understanding of the total self.

Module 8, Counseling Practicum, provides an opportunity for participants to practice counseling skills and to give and receive feedback on the use of these skills.

Module 9, Cognitive and Affective Closure, includes (1) a review of the seven principles of behavior change; (2) cognitive and affective closure of the static groups; (3) the posttest; (4) a review of the major concepts presented in Unit B and a discussion of how participants can use these in their work situations and personal lives; (5) an overview of Unit C and an explanation of the written homework assignment; and (6) an opportunity for each member of the training group to express feelings to any other member.

TRAINING GOALS

The Basic Substance Abuse Counselor's Training Program, Unit B, is designed to place substance abuse counseling in an operational perspective, so that the counselor will be able to:

- Recognize his or her own attitudes and values and the affect these may have on counseling
- Better understand the attitudes and values of others
- Understand the principles of behavior change in the counseling situation
- Apply himself or herself more fully as a counseling resource

THE BASIC SUBSTANCES ABUSE COUNSELOR'S TRAINING PROGRAM
TRAINING OBJECTIVES

I. Trainee will evidence an increase in knowledge of addictions and counseling by 30 percent as indicated by a pre-post test.

A. Given a list of potential counselor tasks and functions, the trainee will identify items which are included in the seven principles of building client-counselor relationship for bringing about client behavioral change as listed in handout #1 and #2.

B. The trainee will be able to list and sequence a list of the seven principles of building a client-counselor relationship for bringing about client behavioral change (see previous objective reference.)

C. The trainee will be able to define the "whole self" in terms of mental, physical physical, and spiritual balance as described by the reading handout "The Whole Self."

D. The trainee will be able to list at least two limitations of the western or linear view of human problems according to the reading handout "The Whole Self."

E. Given a list of human experiences, the trainee will be able to identify those which are social imprints as defined in the reading handout "Sociological Imprints."

F. Trainee will be able to list 2 ways of using social imprints positively in a counseling situation. (see previous objective.)

G. Given a list of terms, the trainee will identify criteria for helpful feedback as outlined by handout "Feedback."

II. Trainees will evidence a statistically significant attitudinal change in at least 2/3 of the areas listed below.

A. Trainee will express a more positive attitude toward the significance of body awareness in the context of counseling.

B. The trainee's attitude toward fully probing and identifying the clients pain (discomfort) is more positive.

C. The trainee will express a feeling of increased importance of the client's acquiring new life skills.

D. The trainee will report feeling different in accepting feedback about self.

III. Trainees will indicate an acceptable level of skill in at least 3 areas as observed by trainers.

A. The trainee will demonstrate three methods of physical and psycho-centering as observed in somatic awareness sessions of Component B.

B. Given a simulated client, the trainee will demonstrate the implementation of the seven principles of behavioral change in a one-to-one counseling setting. (Criteria: observations of trainers recorded on a scale.)

C. Trainee will demonstrate giving constructive feedback to peers about the implementation of the seven principles of behavioral change. (Criteria: Trainer rating on a scale.)

MODULE 1 : INTRODUCTION AND ASSESSMENT

MODULE 1: INTRODUCTION AND ASSESSMENT

FOCUS

Module 1 is designed to stimulate discussion about individual growth and counseling principles. Participants' concerns about individual counseling will be identified and shared with the training group.

LEARNING OBJECTIVES

Upon completion of the activities in this module, participants will be able to:

- Share impressions of the person interviewed with the training group
- Identify at least one personal concern about counseling
- Express a concern about counseling that is felt by at least one other participant

MODULE 1: INTRODUCTION AND ASSESSMENT

PRETEST

The pretest is given to assess attitudes and knowledge before training. This assessment will help trainers gear the session to the participants' level of knowledge.

ASSESSMENT ACTIVITY ONE

Goal

This exercise is designed to determine participants' expectations about training.

Description

Fill out a pretraining questionnaire (on page 9). In dyads, exchange your responses to learn about your partner's concerns for this training session. Then, in small groups, introduce your partner to the group by explaining his answer to item 4: "What specific experiences would you like to occur in these five days?" With the other group members, determine a list of three or four questions that can be recommended for consideration by the entire group. Pick a spokesperson to report to the group.

Comments

PRETRAINING QUESTIONNAIRE

1. Why are you attending this workshop?

2. What do you personally hope to accomplish by attending?

3. What specific skills or new behavior do you wish to develop?

4. What specific experiences would you like to occur in these five days?

5. Is there anything you specifically do not wish to happen in these five days?

6. Additional comments:

ASSESSMENT ACTIVITY TWO

Goal

This experience is designed to help participants identify and understand (1) each others' attitudes and values, (2) the way body movements and posture express feelings, and (3) their own feelings and impressions about another person.

Description

In two groups of approximately 12 persons each, work in pairs to interview one another, at first verbally and then nonverbally. Emphasize attitudes, values, and personal aspects of the individual; avoid statistics. Questions could concern leisure time activities, plans for the future, or expectations from training.

In the nonverbal portion of the interview, concentrate on your partner's body movements and posture, noting areas of tension. Also, think about your own feelings during the experience.

Next, introduce your partner to the large group. Then share your feelings about the experience and the impressions you gained from it.

Comments

MODULE 2 : THE WHOLE SELF

MODULE 2: THE WHOLE SELF

FOCUS

The discussion in Module 2 focuses on interrelationships among the three aspects of an individual: the mental, physical, and spiritual. The classical Eastern and Western theories of the individual are compared and contrasted and then examined in terms of their implications for counseling. During this process participants have an opportunity to examine their own ontological assumptions and the role these play in determining one's attitude as a counselor.

LEARNING OBJECTIVES

At the conclusion of this module, the participants will be able to:

- Explain the concept of mental, physical, and spiritual balance
- Name two limitations in the Western, or linear, view of human problems
- List three advantages of approaching clients from the perspective of the "whole person "

MODULE 2: THE WHOLE SELF

PRESENTATION: "THE WHOLE SELF"

In this presentation, the resource paper entitled "The Whole Self" will be outlined. Emphasis will be on alternatives to traditional Western views of man and on how a counselor's view of man (ontology) affects his or her approach to clients.

SMALL-GROUP DISCUSSION: "THE WHOLE SELF"

In small groups, discuss the presentation. Use the space below for any notes.

THE WHOLE SELF

by

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Prepared

by

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THE WHOLE SELF

The whole self involves an examination of the way we perceive human beings (both ourselves and others). We have all heard the expression "I can't see the forest for all the trees." It refers to a misperception resulting from focusing on a specific part at the expense of the total picture. This corresponds to our perception of the self in comparison to the whole self-concept. We have been focusing on a limited view of the self at the expense of the total picture of the individual. I want to examine our present perceptions, change our focus and look at the whole self, and examine the implications each way of perceiving has for the client/counselor relationship.

The way a society perceives something is reflected in the language it uses (or invents) to describe it and the institutions it sets up for relating to it. For example, a society that did not perceive "love" would have no words for it and no institutions (marriage, courtship) to deal with it. Not only are our perceptions reflected in the language and institutions we invent, but they are passed on from one generation to another through our language and institutions.

Our perception of people who steal from other people is partially influenced by the way our ancestors described them (thieves, crooks, hoodlums) and by the institutions set up to deal with them (court, jail, prison). Since our ancestors deemed it necessary to set these people apart in language and in reality (jail) we learn to perceive people who steal as a threat. Unfortunately, we set many groups apart in language (Negro, alcoholic) and reality (ghetto, treatment program) and communicate to our children the perception that these people are different, undesirable, and threatening.

How do our language and our structures reflect and shape our perceptions of the individual?

In a Western industrial society like the United States, our perceptions of the individual are reflected in and shaped by:

(a) our classification of people according to function (lawyer, housewife, client, counselor);

(b) our tendency to describe people according to obvious physical characteristics (black man, young girl); and

(c) our tendency to rate (judge) people (including ourselves) according to a few either/or standards (good boy/bad boy, pretty girl/unattractive girl, saint/sinner, smart/dumb, success/failure, O.K./not O.K., winner/loser).

Let's look at how each of these affects the way we perceive the individual.

Our classification of human beings according to function is reflected in our emphasis on careers and our increasingly specialized jobs. While this specialization has benefits for mass production, it narrows our focus from the whole self to one small part of the individual. We even tend to define ourselves by our profession (counselor) while ignoring many vital aspects of our lives (husband, father, Catholic, athlete, friend, neighbor, citizen, etc.) that contribute to the whole self.

Our description of people according to obvious physical characteristics also limits our perception of individuals. While it is convenient to classify people according to obvious physical and behavioral characteristics in our busy, mobile, individualized society, it shifts our focus away from the complex whole person to a specific trait of the person that is easy to classify. This also allows us to make generalizations about a person (she is pretty, therefore ...) without bothering to know that person as a human being. This emphasis on the superficial and the obvious may lead a person to believe that the image he projects is all that is important. This narrows his focus on himself from a complex, multifaceted creature to a person who defines himself by the way others react to him.

The tendency of Western society to rate (judge) people according to ill-defined either/or standards

"Good girls don't ..."

"Christians do ..."

"Big boys don't ..."

sets up unrealistic expectations of ourselves and others. By setting up such standards we are making our acceptance of ourselves and others conditional on attaining a certain goal or on not making any mistakes. We are again narrowing our focus on the self to one area and letting our approval or disapproval of the person hinge on success or failure in this narrow area. It also communicates the message that a person isn't complete until he achieves some success in a particular area. We focus on what we aren't rather than what we are. The whole self involves widening our awareness to focus on all the things we already are.

Now let us change our focus to look briefly at a more primitive, integrated society with an Eastern view of the self. Remember, this is a totally integrated society where all the members contribute to fulfilling one anothers' physical, mental, and spiritual needs. It is something like the extended family. Here the individual is not categorized in terms of function because all functions are shared by all members of society. Each task is viewed as equally important to the functioning of society. Nor are individuals categorized by obvious physical characteristics. In an integrated tribal or communal society each person can be known individually and there is no need to categorize. Many American Indian tribes never state the obvious in their conversation so the individual is not perceived, by himself or by others, as just a lawyer, or a hunter, or a housewife, or a tall man, or a pretty girl. The "Eastern" society encourages each individual to include the vast array of physical, mental, and spiritual functions when defining his concept of himself and his concept of others, because all these functions are integrated, not separated, within the society. The individual is a reflection of the society that fosters him. He is a totally integrated individual with all aspects of his "self" contributing to his perception of the "self." Each aspect of the self is viewed as equally important to the functioning of his society. Moreover, with so many aspects of the self included in the self-concept it is impossible to judge the individual for a failure to achieve in any one area. The society isn't dismissed because of a failure in one area and neither is the individual. The focus is on what the individual is, not what he is not or should be.

Obviously, we cannot all participate in an ideal tribal society, but the comparison between the Eastern and Western views of the individual brings up some important considerations for counselors. Helping our clients understand their behavior and recognize their problems requires someone with a broad perspective of the individual. Since we have grown up with the Western perception of the individual that tends to categorize and judge, our perceptions of our clients and ourselves may be limited.

Western Society separates the mind, body, and spirit. We have separate institutions for each component (mind--schools, mental health centers; body--health spas, sports; spirit--church). We turn to different specialists to help us with problems in each area (mind--psychologist; body--doctor; spirit--minister). In fact, we even set aside specific segments of time for dealing with our spiritual self (Sunday morning) and physical self (weekend sports, bedtime, sex at a specific time) while we ignore these integral aspects of the self the rest of the week. Similarly we often deny our own mental health needs and keep our problems inside (which makes them seem gigantic and unmanageable) rather than admitting these problems and dealing with them openly (which makes them smaller and more manageable). We only acknowledge the needs of our mind, body, and spirit when it is appropriate to acknowledge them. We let the Western idea of appropriate/inappropriate, right/wrong, good/bad, tell us when (if ever) it is permissible to talk about or even be aware of entire parts of ourselves. By shutting awareness of the mind, body, and/or spirit because certain thoughts, feelings, and actions are socially unacceptable, we are keeping ourselves from knowing ourselves. We are denying our own needs in order to live up to the expectations others have for us. In effect, we are living for the image we project, not for ourselves.

For example, I find that it is much easier to share myself in an accepting environment like training than in most other situations. At training, I feel free to get in touch with the various aspects of myself that I have learned to ignore on the job and in less accepting social situations. In a caring community like training, I can share what is on my mind (hopes, worries, confusion) without worrying what others will think. Moreover, I know that sharing what is on my mind will give me useful feedback about my mind and how it works and I will grow through self-understanding.

Similarly, I feel free at training to explore my spiritual self. I can bring my spiritual questions, beliefs, doubts, fears, and longings out in the open and learn how the spirit manifests itself in me and in others. This brings my spiritual self into clearer focus and increases my awareness of my spiritual self. In the nonjudgmental, nonlabeling atmosphere of training I can get beyond the shallowness of ill-defined labels like believer/atheist and beyond the rigidity of maxims like "Christians should..." and really begin to explore my spirituality.

This nonjudgmental atmosphere also increases my awareness of my body and the messages it sends me. Our bodies are constantly sending us messages. My body tells me when I am too warm or cold, when I need to urinate or defecate, when I am hungry or thirsty, when I am sexually aroused, when I am sleepy, and when I am in pain. However, I have learned to ignore many of these messages in my daily life. For example, I often ignore messages of pain from my body because pain is not comfortable. I learn to suppress my hunger pangs until lunch when I can deal with them. I may suppress messages such as sexual arrousal because there is not a socially acceptable way of dealing with the feeling at the time. By denying socially unacceptable or uncomfortable signals from my body I develop a pattern of ignoring a part of myself. I let my mind censor the messages from my body thereby cutting off awareness of a part of myself. After spending a week in the nonjudgmental, accepting atmosphere of training, I am more in touch with the messages by body sends me. For instance, at the beginning of a week of training I tend to overeat. My eyes are bigger than my stomach. At the end of the week I seldom overeat. The channels of communication between my mind and body seem to be open and I am in better touch with my appetite. My eyes are no longer bigger than my stomach.

In training, as in Eastern tribal society, the emphasis is on exploring, learning, and becoming aware. The Western concepts of getting the "right" answer, competing for grades, and performing to meet others' expectations do not apply. In training I feel free to learn who I am, not who I "should be." I become more aware of my mind, my body, and my spirit, and this increased awareness itself has healing qualities. I feel more whole and balanced and I begin to understand that ignoring my mind, body, or spirit is fragmenting in that it closes off intrapersonal communication channels and prevents me from knowing myself and recognizing my own needs. Moreover, this fragmentation throws the entire system out of balance as unrecognized needs remain unmet and the resulting tension affects other parts of the self. Unrecognized hunger needs, for example, remain unmet and can make us cranky and irritable. By staying in touch with hunger, we may not be able to satisfy our hunger immediately, but the awareness of the hunger can help us recognize where our irritability originates and find more suitable ways of dealing with it than yelling at our families.

Our clients also need a safe nonthreatening place to explore themselves and their unrecognized needs. It is our job as counselors to provide a nonjudgmental atmosphere where the emphasis is on exploring, growing, and learning. Rather than molding our clients into a preconceived ideal that further fragments human beings by telling them what they should be, we must encourage our clients to grow by exploring and becoming aware of all aspects of themselves rather than one narrow aspect like their image or their alcoholism. We must help each client focus on the forest rather than the trees and find the healing, nurturing parts of himself that can help him discover the healthy, balanced, whole human being beyond his fragmented self.

MODULE 3 : FREE THEATRE

MODULE 3: FREE THEATRE

FOCUS

"Free theatre" is an exercise in risk-taking and nonverbal communication. It is designed to help group members feel closer to one another and to help participants understand the importance of a client's nonverbal expressions. By experiencing the nonverbal expression of emotions the participant will be better able to perceive the significance of his or her clients' nonverbal expressions.

LEARNING OBJECTIVES

At the end of Module 3, participants will be able to:

- Identify two feelings that they experienced when responding nonverbally to the "free theatre" exercise
- Identify which role made them feel most comfortable
- Identify which role made them feel most uncomfortable

MODULE 3: FREE THEATRE

ACTIVITY ONE: FREE THEATRE

Goal

This exercise is designed to help group members feel closer to one another and to help participants understand the importance of a client's nonverbal expressions.

Description

This activity is nonverbal. One half of the group is given a word such as "joy" to act out; the other half is given its opposite, "anger." After a few minutes the word assignments are reversed. Act out your interpretation of each emotion.

Next, act out a role that you are assigned, such as "nice guy" or "bully." Then write down the strong feelings you experienced while portraying this character. Do the same when the roles are reversed.

Decide which role you most enjoyed and which made you feel the most uncomfortable. Act out first the favorite role, then the least favorite, noting your feelings as before. Compare these notes with the first ones and discuss your thoughts with the group.

Comments

MODULE 3: FREE THEATRE

ACTIVITY TWO: STATIC GROUPS

Goals

The goals of the static groups are (1) to provide for continuity in training through conceptual integration of material presented and (2) to develop a supportive atmosphere in which personal concerns can be expressed and handled.

Description

The static groups meet daily throughout training, usually at the end of each day's activities. You may discuss feelings that you have about the training, or any problems that may need resolution. The EIAG model (see following page) is used during these and other discussions in this course.

Comments

THE EIAG PROCESS

The EIAG process (*E*xperience, *I*dentify, *A*nalyze, *G*eneralize) requires that any experience must follow certain steps so that it will become a *learning* experience for the individual (I-A-G).

- *Identification* of the elements of the experience that were significant to the individual.
- An *analysis* of why those elements were significant and how they came to be significant to the person.
- A *generalization* of what was learned in the experience to the individual's life.

The static groups will use this process in concluding each day's activities.

MODULE 4 : SOMATIC AWARENESS

MODULE 4: SOMATIC AWARENESS

FOCUS

Somatic awareness refers to awareness of the body. Module 4 is designed to bring the physical, spiritual, and mental elements of the training into harmony. The activities, such as yoga, meditation, and breathing exercises, are based on Eastern philosophies and practices and on Reichian theories of body processes and their relation to spiritual and mental health.

LEARNING OBJECTIVES

At the end of Module 4, participants will be able to:

- State the importance of body awareness as it relates to counseling
- Demonstrate three methods of physical and psychological centering
- Explain two ways to help clients by using somatic techniques

MODULE 4: SOMATIC AWARENESS

ACTIVITY: SOMATIC PROCESSES

Goal

This activity is designed to give participants practice in several somatic techniques and to make them aware of the possible application of these techniques in one's personal life and in the counseling situation.

Description

Following the directions of the trainer, practice several somatic techniques, such as yoga, meditation, breathing exercises, and energy flow exercises. While you are practicing these, the trainer will explain the origin, use, and possible application of these techniques in your personal life and in the counseling situation.

Comments

DISCUSSION

Discuss your feelings, impressions, or ideas about the experience you have just had. Use the space below for any notes.

BODY AWARENESS AND SUBSTANCE ABUSE COUNSELING:
AN INTRODUCTION

by

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January 1977

BODY AWARENESS AND SUBSTANCE ABUSE COUNSELING: AN INTRODUCTION

In recent years, one of the emerging trends in the counseling profession has been the utilization of the human body as a diagnostic tool and as a therapeutic focus. Numerous articles, books, abstracts, and other literature have been produced which relate the significance of body awareness and manipulation as a means of preventing and curing the pain prevalent in our everyday experience. Paperback books about yoga and body language proliferate at our corner drugstore newsstands. Medical journals and scientific abstracts now include the same topics. Even American Airlines features articles on yoga and tension release in its monthly magazine for passengers.

Previous to this recent tidal wave of attention to the human body, the only people seen as qualified body technicians were doctors, nurses, and physical therapists. The Age of Specialization was very provincial and was not integrated: mental health professionals worked with the mind and physicians focused on the physical. Today, the concept of the whole person is being revived and is evidenced by a greater percentage of medical students going into family practice and by therapists who now explore a client's diet, exercise habits, and physical health as well as his mind and emotions. Growing validity is being given to the belief that psychological processes (as well as spiritual) are expressed in and by our bodies. Doctors are now estimating that 60-70% of all their patients have psychosomatic illnesses.

Helping professionals, from doctors to ex-addict/recovering alcoholic counselors, are now devoting more energy and time to developing an understanding of how our body, mind, and spirit are all interrelated and interdependent. Through research and through personal experience we are discovering that our bodies, minds, spirits, feelings, interactions, and behavior are all manifestations of our true essence.

In this paper, I would like to explore the concept of body or somatic awareness as a means for understanding and helping dependent people. This concept of somatic awareness revolves primarily around the assumption that if I have complete knowledge of myself, I can then choose to be the "way I want to be."

One obvious and real way to gain complete knowledge of myself is to be aware of everything I do and the way I am. I am the words I talk. I am my farts. I am the tension in my neck. I am my posture when I talk to a woman. I am the person who takes a drink of J & B Scotch before I talk to anyone. To be aware of my behavior and my total self is a prerequisite for controlling my own life.

PRIMARY CONCEPTS OF SOMATIC AWARENESS

Although there are many, many techniques and approaches to somatic awareness, there are five primary concepts which are more or less common to most somatic approaches. These five concepts are: Breathing, Centering, Grounding, Deep Relaxation, and Energy Flow.

It is important to remember that when we focus our awareness on our body that the mind is the information processor for our awareness as well as being another part of our body. Thus, the mind is an integral part of the somatic awareness process. The key to somatic awareness is to allow the mind to receive unfiltered messages from the body. The instant we begin to explain or justify these messages we lose their meaning. It is also important to know the situation which surrounds a certain message or sensation. It is significant to be aware that my breathing becomes shallow and rapid *when* I talk to a woman *because* I was weened at an early age, etc. *Awareness* does *not* need a *why* or *because*. Thus, as I explore the five primary concepts of somatic awareness, keep the function of the mind in your conscious as you conceptualize somatic awareness.

Breath

Of all our body processes, breath is the only one which can either be controlled or automatic. Breath is a part of both our conscious and our unconscious. It is connected to our deepest feelings as well as our minds. We all (I hope) have experienced a panting as we become sexually aroused or held our breaths as we narrowly missed having an auto wreck. These are both examples of breath hooked to our deepest feelings. And yet we can focus on our breath and breathe the way we want.

Breath is seemingly easy to control. Yet the average person gives up conscious control of breath to his autonomic nervous system and goes through life without controlling his breath. Our breath brings in more energy and nourishment and expels more toxins than any other body process. Yet how many of us allow as much daily consciousness to breathing as we do to eating, urinating, defecating, and sweating?

Focus on and awareness of breath can help us gain control over our emotions. Neurotics and psychotics have definite breathing patterns. Each of us also has a breathing pattern. Knowing our pattern can help us see when and how we block our energy and potential. If I feel nervous, I can focus on my breath, realize I am breathing shallowly and in my throat, breathe deeply from my belly and feel more relaxed.

Breath is a two-way street. It can facilitate awareness of our feelings and unconscious as well as give us control over our emotions.

Centering

One trait which is overwhelmingly common to people who depend on substances is a feeling of being overrun or being controlled by outside influences. This is often manifested by over concern with "what others will think," with "shoulds" or "ought to's," or with having a room arranged the "right way." Most of our clients center themselves in their environment; on other people or on significant material objects.

Somatic centering concentrates on enabling us to focus on our natural or physical center. This center is located near our navels. When we are focused there we are in better contact with our feelings and desires. When we come from there or know what is there, we experience more power.

If I am not focused at my natural center, I will be off balance. My muscles will have to strain to hold up my body instead of allowing my skeleton to support me. Energy and power will be diverted from achieving my goals to holding up my body. By using various centering techniques we can go within ourselves, know our own feelings and desires, and not waste energy supporting our out-of-balance bodies, trying to manipulate our environment or trying to meet the expectations or values of others.

Grounding

As a culture and civilization, we are very rational, conceptual, and head oriented. We spend the majority of our time thinking, looking, and talking. We don't spend much time doing or feeling. We watch people being killed on T.V. shows or the news. We will talk about it, but we usually don't do anything to stop it or don't cry or vomit at the sight of it. Most of us talk about sex, think about it,or watch it on T.V. Yet, most of us have sex only once or twice a week. Dinosaurs became extinct when their brains became too small for their enormous bodies. Will we too destroy ourselves by staying in our heads and fantasies and allowing our bodies to degenerate?

Grounding focuses on helping a person gain contact with physical reality, to stand on their own two feet. If we understand the pain and pleasure of physical existence, we can use that grounding to balance our ideas and our dreams.

Deep Relaxation

Historically, deep relaxation has been used for ages as a therapy tool and as a means to control tension. Developed in the West by Mesmer, deep relaxation is often kept under control of the therapist, especially if deep hypnosis is employed. In the context of somatic awareness, deep relaxation can be safely used by us and our clients as a means of taking responsibility for ourselves.

Deep relaxation is based on the assumption that most of us seldom fully relax. Operationally, it involves experiencing tension, then experiencing relaxation, and finally developing an awareness of the accompanying feelings. Once we are aware of what tension feels like and of what relaxation feels like, we can then begin to control ourselves when we are tense by consciously relaxing the tense parts of ourselves.

Many of our clients use substances to block tension or to reduce it. We all know that alcohol loosens us up, don't we? Deep relaxation allows us to take control over our tensions nonchemically.

Energy Flow

Nearly all Eastern belief systems include the idea that energy flows through our bodies. While these energy flow theories may vary in complexity, terminology, or application, they all generally agree that energy grows through the body similar to electrical current. Physical tension or rigidity is viewed as a block in the energy flow which hinders us from maximizing our potential power.

One such energy flow theory which is applicable to counseling is derived from the science of Kundalini yoga. The theory says we have seven centers or chakras of energy in our bodies. These chakras are located along the spine and correspond to the location of nerve plexis and glands. In Figure 1, a schematic drawing of the body illustrates the general location of the chakras and their corresponding meaning. Blockage in any of the seven chakras prevents energy flow through that block (hang-ups). These blockages can often be seen physically as tension or rigidity. For example, those of us who have blockage in the fifth chakra will have trouble expressing what we want to communicate. Tension or constriction may be seen or felt in the throat or tongue.

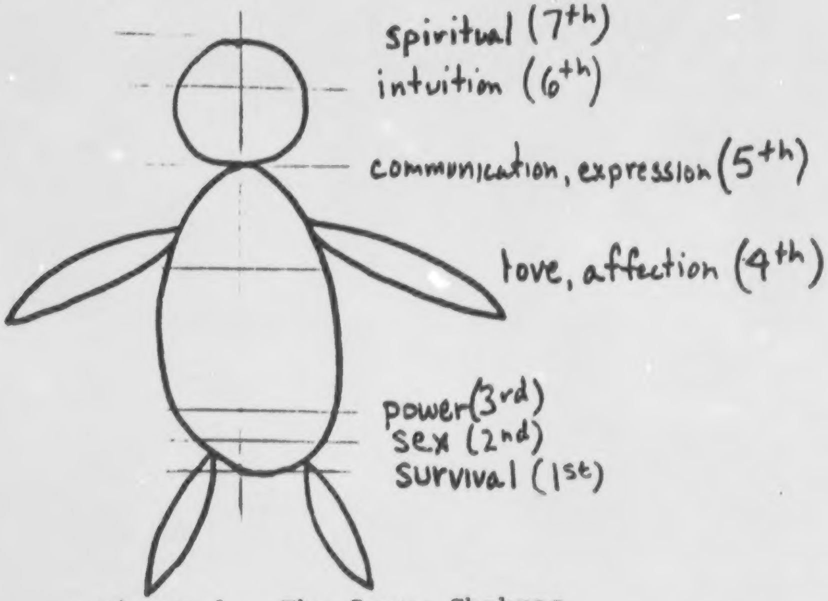

Figure 1. The Seven Chakras

By focusing awareness on each chakra, blockages can be identified and released. Such awareness can be developed by using somatic techniques as well as meditation, encounter, or other therapy.

SOMATIC AWARENESS AND SUBSTANCE USE

In working with substance users, somatic awareness can be utilized in three basic ways:

As a Prevention Alternative to Substance Use

Dr. Allen Cohen has theorized that everyone has a desire for specific levels of experience which can range from relief of physical pain to communion with God. Each of us has many choices to fulfill the specific desire for experience which we have. Substance use is many times an easy and instant way to satisfy such desires. Somatic techniques are ways of satisfying some of the needs we have in a nonchemical way. Somatic techniques are alternative methods for satisfying our desires and can act as a prevention tool in reducing substance use. For example, Kundalini yoga can fulfill my desire for a higher level of consciousness. If I have a desire to control and reduce my tension level, deep relaxation is a method I could use instead of doing heroin.

As a Diagnostic Tool

As a counselor I can use my knowledge of body language to identify problem areas of my clients and to validate my intuitive assessment of my client and her history. If a client avoids looking at me, has much tension in her jaw and throat, sits with her arms and legs crossed leaning back, or has shoulders hunched over her chest, I am getting valuable information as to her self-concept, interpersonal skills, way of expressing anger, degree of defensiveness, and openness to receiving affection. The nonverbal communication expressed in one minute is often more honest and valuable than the information gathered through long hours of verbal psychosocial histories.

As a Rehabilitative or Growth Method

Somatic awareness can be used to enable us to return ourselves to previous states of well-being, to endure stress, or to develop new skills or behavior. Four areas I would like to briefly focus on are: (a) Bodily damage incurred while using substances, (b) Detoxification, (c) Development of insight, and (d) Aquiring new behavior.

(a) Those of us who have a history of substance use have frequently physically damaged ourselves. We have reduced the ability of our bodies to function either by accidents occurring while in a substance induced state, by the act of injecting chemicals into our bodies or by the gradual deterioration of our bodies caused by toxic substances or malnutrition. We can use various somatic techniques to improve the physical condition of our bodies by regenerating damaged tissue or reducing physical limitations. For example, I can stimulate a deteriorated liver by using the energy flow concepts of accupressure or shiatsu. If I was blinded in one eye in an auto accident while drunk, I can use yoga to reduce the rigidity in my neck. Thus, my head can rotate easier, compensating for a lack of peripheral vision.

(b) During detoxification from substances, we can utilize meditation, deep relaxation or yoga to aid us in reducing the tension or stress we experience as we withdraw from substance dependency.

(c) Before we engage in a new behavior, we must be aware of ourselves. As a counselor, we can many times facilitate our clients' development of insight by focusing on their blockages or body presence. Using breathing, deep relaxation, energy flow, and/or centering techniques we can aid our clients in identifying in a very concrete and undeniable way the tension and behavior blockages of their bodies. "One picture is worth a thousand words."

(d) After our clients develop insight, various somatic methods can be used to help a client in acquiring a new desired behavior. If our clients have trouble making contact in interpersonal relationships, we can have them practice talking with us with open postures and with eye contact. If our clients have become aware that they block expression of their feelings by constricting their throats and biting their tongues, they can use yogic chants or relaxation techniques to consciously relax their throat and tongue, thereby opening up their expressing. New behavior requires both insight and practice.

I have explained somatic awareness and counseling as I understand their relationship. My purpose was to stimulate your interest in learning more about somatic growth processes. If your interest in the body has been aroused, I would urge you not to become a "body specialist" but to integrate your new knowledge or skills with your other skills and become a "whole person and counselor."

MODULE 5: SOCIOLOGICAL IMPRINTS

FOCUS

The most valuable resource that a counselor brings to the counseling situation is himself or herself. But implicit in this is also its corollary: the counselor can also be the most damaging element in the therapeutic situation, especially if the counselor's own values and attitudes are imposed on the client. Each person's values and attitudes are derived from the positive and negative experiences of life. A counselor must learn to recognize his or her own "imprinted" values and attitudes *and* be aware that clients have their own imprints that affect their behavior.

In this module, attitudes and values are explored to help participants understand themselves and others. Because deeply imprinted values are often the most compelling as well as the most obscure, the activities in this module may be more intense than those in previous modules. They should help establish a climate conducive to the intensive growth activities in later modules.

LEARNING OBJECTIVES

At the end of the module, participants will be able to:

- Explain the importance to the counseling situation of understanding one's own imprinted values and attitudes
- Explain the importance to the counseling situation of being aware of clients' imprints
- Explain two ways that imprints may be used positively in the counseling situation
- Identify three imprinted values or attitudes of which they were previously unaware
- Identify three values and attitudes imprinted on others of which they were previously unaware

MODULE 5: SOCIOLOGICAL IMPRINTS

PRESENTATION: SOCIOLOGICAL IMPRINTS

In this presentation, the nature of imprints and how they vary according to gender, racial-ethnic background, age differences, and socioeconomic status will be discussed. The presentation will explore the potential influences of these imprints on the counseling relationship. *Use the space below for any notes.*

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SMALL-GROUP ACTIVITY: IMPRINT EXPLORATION

Goal

This activity is designed to help participants understand how sociological events can affect their attitudes and values.

Description

In small groups (selected by age), discuss and list on newsprint the major sociological and cultural events that occurred in your life, especially during the first 18 years. Then list the impressions or imprints *you received from each event and some of the affects these now have on your attitudes toward people and issues. For example, if you list* the Great Depression *as an event, you might list* Don't waste anything *as the imprint you received and* Have difficulty understanding young people who spend recklessly and who take their material advantages for granted *as the affect the imprint has on your attitudes.*

A spokesperson from your group should present the results of the activity to the entire group. Other group members sit at the front of the room during this presentation. The spokesperson should note (1) the major sociological events that were listed by the small group and (2) the group profile: *how group members tend to view persons (black, poor, older) and issues or situations (crime, welfare, draft evader amnesty, busing, presidential elections).*

Comments

STATIC GROUPS

Goal

The goal of this activity is to help participants understand the affect of early cultural and soliological imprints on their lives.

Description

Work in the same groups established for the first static group activity and consider the experiences of your first 18 years. Under the headings (1) Family, (2) School, (3) Community, and (4) Religious Experiences, list events that impressed you and that now affect your actions and reactions. Then share these sociological imprints with the rest of the group, focusing on their implications for your present life.

Consider the implications of imprinted values for the counseling situation.

Comments

SOCIOLOGICAL IMPRINTS

by

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SOCIOLOGICAL IMPRINTS

What I want to talk about in this article is what kind of person you come to be as a result of your life's sociological experience. I want also to share with you something about the manner (the process) in which we all become what our social/ cultural experience determines for us. Finally, I should like to touch on some of the implications this process has for the client-counselor relationship in which the goal is client behavioral changes.

Let's back up a bit and take a look at what it means to be a human being, at least in part. All humans have certain basic needs to fill--for food, nourishment, for sex, for freedom and independence, for belonging to other humans, for loving, for being loved and for being of some value or worth to self and others. These are internal or intrapersonal (within the self) needs and in our history Sigmund Freud probably gave these needs (drives to fill them) very widespread attention. He focused the world on viewing the human personality in terms his inner, personal needs, especially his sexual drives. He underscored the individual personality and lifted it to a place of supreme importance.

Most of us devote great energies to meet these internal needs. When they are grossly unfilled, we are in trouble as persons. One difficulty in meeting these needs is that they frequently are in conflict with each other. I find, for example, that I have to give up some of my needs for freedom to be myself in order to fill my sexual needs or that I must set aside needs to be loved in order that I may love.

There is another category of human needs, however, which also shapes the personality. We may call these external needs or drives in that they are created by sociological influences (the environment, society, and culture) which impact upon one's life experiences. Some of these sociological influences may be identified as family, church and/or religion, community, and school and/or education. Another such influence may be identified as the major sociological events which impact life. Here we might think of the great depression, World War II, the technological explosion of the forties and fifties, the civil rights movement, Viet Nam, etc.

The great proponent of social consequences has been Karl Marx who subjugated the needs of the individual to the needs of society, or class, and his philosophy stands in stark contrast

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to Freud who exposed the individual. The point to make here is that to deal with the totality of personality, both intrapersonal needs and needs shaped sociologically must be taken into account. Historically, psychiatry and therapeutic counseling have stressed the Freudian approach, perhaps overly so, to the exclusion of sociologically induced personality traits. For this reason, the remainder of this paper will deal with socially/culturally induced personality traits, which become evident as we uncover a person's standards, norms, values, biases, and prejudices. These traits, determined in a very real way by society, especially in one's formative years, provide the answers to: (1) How I see (feel about) myself. (2) How I see (feel about) others, especially those different from me. (3) Who am I? What we are saying is I am determined by society; I am the product of my sociological life experiences.

In the Substance Abuse Counselors Training we will use the term "sociological imprints." The word "imprint," as we are using it, comes from the discipline of behavioral science. A behavioral researcher, Konrad Lorenz, used the term in describing the initial stimulus given to very young animals. He noted that such a stimulus could arouse a particular response reaction and that it frequently was the case that this stimulus would become the only stimulus which could arouse that response in the animal from then on. As an example, he removed the mother from the sight of a newborn gosling and substituted his hat as the first object the gosling saw. He noted that the gosling would follow the hat wherever it went in the same way goslings would follow their mothers normally.

In a parallel way, psychological theory holds that what society lays on us in our early, developmental years has a profound effect on our responses for the rest of life. The social effect may be very obvious or quite subtle. As a human being, I may be most aware of how society has shaped my life responses or these social effects may be buried within and hidden from me. That is, sometimes society's impact on my personality is overt and obvious. At other times, it is subtle and subconscious. The messages I received about my toilet training, for example, have a subtle effect on how I respond now to genitals, sex, women, etc.

I do not always have to respond in accordance with society's impact on me. I may go in the opposite direction--react in an opposite way. My family, community, and church may have extolled religion, yet my early religious experience may have been so traumatic that since growing up I have never gone to church and have a very difficult time tolerating church people.

Another characteristic of socially induced responses has to do with what I will call "mixed messages." Mixed messages produce confused life responses. Take, for instance, the growing child who will establish some standards for himself with respect to his behavior around his use of alcohol. Depending on where he looks (T.V., parents, church, country club, neighbors, peers, local bar), he will find almost any drinking behavior accepted by some. The fact is that American society does not have a norm for alcohol use. It has many norms and these are in contradiction. The messages he receives about drinking behavior are "mixed."

There is still another kind of life experience which is not uncommon for those of us who find themselves in the substance abuse helping industry. A number of us have had what I will call a "conversion experience" around our substance abuse behavior. Like any deeply moving religious awakening, moving out of addiction (drugs/alcohol) may be a very profound personal experience which stamps one's personality with deep imprints. Although seldom occurring in the formative years (usually much later), the prints are etched deeply in the personality. Here we may have the "ex-addict syndrome" of which we spoke in the Basic Course [Unit A], which markedly affects our relationship with ourselves and others.

Perhaps you will recall some of the messages you received in your developmental years. Here are a few examples:

"Don't speak (children) unless you are spoken to."

"Cleanliness is next to Godliness."

"God

---knows even if I (parent) don't (know what you've done)."

---is loving."

---will fudge."

---will forgive."

"Hard work is a virtue."

"Clean up your plate."

"Boys don't cry."

"People on welfare are lazy."

"Catholics are ---"

"Women are ---"

"Black is beautiful."

"--- is scary."

"Nice girls don't ---"

"Pre-marital sex is ---"

"Honor thy father and thy mother."

"Love your neighbor as yourself."

"Poor people are ---"

"Drinking is ---"

"God, guns, guts -- let's keep 'em all."

"Kids are --- these days."

"Work, save, get ahead."

"You shouldn't get angry."

"Waste not, want not."

When I recall some of these messages that I received as a youngster, I get a kind of nostalgic amusement. Not so funny, however, is the way some of them have a manner of complicating my way of looking at myself, situations, and others today, years later. Let me share with you what I mean from my own life. As a kid, church for me was a great experience. I sang in the men boys choir, played on the choir basketball team, sang a few solos for which I received recognition. God, for me, had a special relation to church people. He loved them, forgave them, and expected them to model this behavior among themselves and to others. Now move from 1935 to the early '60's. Yours truly is the rector of a medium-sized congregation in a medium-sized conservative community. Civil rights and Viet Nam are hot issues nationally. Christians should be out front in leading the assault against United States involvement in Viet Nam and practices which relegate minorities to second, third rate status. Right? The church, of all institutions, should be in the action. Right?

The upshot of this for me was to alienate myself from the folks (congregation) I was sent to nurture and ultimately was responsible in an important part for my leaving the parish ministry altogether.

What I wish to emphasize, however, is that *my early messages* about who and what church people should be was most unrealistic in terms of who they in fact were in a small conservative Ohio city. Furthermore, my lack of awareness of who my parishioners were in terms of *their early* conservative, protestant ethic, moralistic *messages*, made it well nigh impossible for me to know who they were. Obviously, our relationship suffered and my role as a helping person became minimal.

This leads me to want to say a few things about sociological imprints and the counseling relationship. The sociological experiences, the people and events which interracted with our lives in our formative years, shape how we see ourselves, shape the image we present to others, shape how we see the issues of life, and shape how we see other persons--especially if they are different from us. They determine how we view marriage, living together with premarital sex, poor people and welfare, minorities and civil rights, government and capitalistic institutions, older/younger persons, drug/alcohol use, etc. etc. They determine as well how we see ourselves; our attractiveness, intelligence, worthiness--our hopes and aspirations.

As counselors, we have the responsibility for managing the client-counselor relationship. That means two persons--the client and yourself. It's very important for you to know where you are coming from or as we so often say, be in touch with yourself. You need to be aware of how those early imprints are affecting your present responses to your client. Are you reacting to your past? Or are you acting objectively in response to your client? A counselor's real attitude has a way of "getting through" in spite of covering efforts. Further, a counselor's attitude about his client with respect to approval/disapproval, success/failure is frequently self-fulfilling. Your client will tend to give you what you expect of him. So much for the counselor and his awareness of his own imprints.

But the counselor is involved, as we have emphasized in the Basic Counselor's Course, with habilitating his client. Among other skills counselors are responsible for assessing are his client's intrapersonal and interpersonal skills. It is critical, then, that he be aware of how his client's sociological imprints have impacted his (the client's) own self-concept (intrapersonal) and how these same imprints influence his responses to others (interpersonal). The habilitation process, then, becomes training his client in these two skill areas where they are deficient.

In summary, sociological imprints of client and counselor impact the client-counselor relationship and need to be dealt with creatively if client behavioral change is to occur. Further, habilitation calls for training clients in inter- and intrapersonal skills which have not previously developed for the client because of the negative impact of his sociological/cultural life experience in his formative years.

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MODULE 6 : PRINCIPLES OF BEHAVIOR CHANGE IN COUNSELING SITUATIONS

MODULE 6: PRINCIPLES OF BEHAVIOR CHANGE IN COUNSELING SITUATIONS

FOCUS

A codification of the principles of behavior change is presented in Module 6. Within the context of these principles, particular counseling methods and techniques are examined. The work of some major therapists and schools of therapy is considered, but no specific counseling techniques are espoused or rejected.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Name seven principles for behavior change in the counseling situation
- Describe the difficulties that can be encountered when one of the principles of behavior change is overlooked
- Present a critique of at least one major counseling technique within the context of the principles of behavior change

MODULE 6: PRINCIPLES OF BEHAVIOR CHANGE IN COUNSELING SITUATIONS

PRESENTATION: THE SEVEN PRINCIPLES OF BEHAVIOR CHANGE

A discussion of the principles of behavior change based on the resource papers will be presented. *Space for notes is provided below.*

ACTIVITY: REVIEW OF A MAJOR THERAPEUTIC TECHNIQUE

Goal

This activity is designed to demonstrate a major therapeutic technique and to help participants understand how the principles of behavior change are used in this technique.

Description

Use the Film Viewing Worksheet while watching the videotape to identify those principles of behavior change used by the therapist. A discussion will follow.

Comments

STATIC GROUPS

Goal

The goal of this discussion is to help participants understand the seven principles of behavior change and their use in the counseling situation.

Description

Discuss the presentation, adding your own ideas to those expressed by the trainer. Then refer to your Film Viewing Worksheet for a discussion on the principles used in the videotape. Consider how these principles may be used in your own career.

Comments

SEVEN PRINCIPLES OF BEHAVIOR CHANGE
FILM VIEWING WORKSHEET

1. Establish relationship (explicit, empathic)		
2. Focus on here-and-now pain		
3. Opening feedback channels		
4. Formulation of problem		
5. Explore options/alternatives		
6. Risk/integration		
7. Action plan (explore contingencies]		

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SEVEN STEPS OF BEHAVIOR CHANGE

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SEVEN STEPS OF BEHAVIOR CHANGE

The following is an outline of the steps people go through to accomplish behavior change. Each step is preparatory to the next. When a counselor is not experiencing the success anticipated, it is often due to the omission or inadequate development of one of these steps. A full understanding of this process will provide each counselor with a built-in self-assessment procedure.

This outline or framework within which to conduct counseling is not a technique or mode of therapy (such as gestalt, transactional analysis, etc.). Rather, it is an overall framework within which any mode of therapy can be conducted.

1. *Establishment of a relationship which is explicit and empathic.* The relationship must be explicit; that is, it must be clearly understood why the client and counselor are together and what is expected. The relationship must also be empathic. The client must feel and understand that the counselor is genuinely interested in the client. This interest needs to be the primary consideration in the relationship.

2. *Focusing on the pain or discomfort in the here and now.* Focusing on the here and now is the only way to solve currently existing problems. Rehearsing history can be cathartic, but rarely therapeutic. There are few lives which have not had sufficient conflict and unpleasantness to allow a patient to dwell on negative aspects of his or her past. If this is what the counselor expects or allows, this is what will occur.

3. *Opening feedback channels in both directions.* Counselors have the responsibility to promote open feedback. To do this they must model both giving and receiving feedback. This implies both honesty and openness in the counseling relationship.

4. *Formulation of the problem.* This often is called "insight" and, as such, terminates many therapies. Often, once the counselor helps the client discover "what the real problem is," the counselor feels his or her job is over. Actually, a clear and accurate formulation of the problem is the step which leads to the steps of behavior change.

5. *Exploring options.* Once the problem is identified, it is important to explore optional behaviors open to the client. After alternatives are explored the counselor should assist

the client in selecting one which appears most appropriate.

6. *Integration.* This step prepares the client to risk the new behavior. In order to do this the client must be able to envision, believe in, and be able to implement the new behavior.

7. *Exploring Contingencies.* It is important to explore the possible success or failure of the behavior, possible reactions to it, what to do if the client fails, etc. This helps the client realize and be prepared for the possible outcomes. In this manner the counselor helps prepare the client for the myriad of reactions which the new behavior may cause. This sets up feedback and further counseling work when the client reports back.

FUNDAMENTAL PRINCIPLES
OF
THERAPY

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FUNDAMENTAL PRINCIPLES OF THERAPY

The following seven principles appear to be fundamental in therapy, regardless of one's theoretical orientation or technical approach.

1. Therapy cannot be done outside of a positive human relationship. This relationship is generated by an *active interaction* between patient and therapist without the therapist losing objectivity nor utilizing the client to satisfy the therapist's own needs (*genuineness* -- Rogers).

In order to establish this relationship a therapeutic approach or attitude is necessary which includes the following six facets:

a. *HOPE:* Both the therapist and the client must firmly believe that a positive result will occur as a result of their interaction.

b. *CONFIDENCE:* The therapist must be confident in his own ability and the approach being used. The client's self-esteem is similarly a critical issue and almost without exception is a focus of therapy.

c. *INTRUSIVENESS:* The therapist must work to become a significant force in the client's current life situation. He must intrude between the client and his symptoms, and/or between the client and his current life situation in order to become a significant force for change. The goal here is for the client and the therapist to view themselves as a partnership to deal with the life problems of the client.

d. *EXPLICIT EMPATHY:* To be distinguished from sympathy, empathy is crucial if a therapeutic partnership or alliance is to become established. It is, in fact, the royal road to a therapeutic relationship and allows for more thorough understanding. The empathy must be explicitly conveyed if its full value is to be realized. Empathy involves subjectively placing oneself in the life situation *as if he were the client* in order to understand intellectually and emotionally the patient's existential experience. At the same time, empathy implies the retention of sufficient therapeutic distance so that the therapist's creative coping capacities and strength remain available to assist the client.

e. *WARMTH:* A genuine warmth and concern *must be transmitted to the extent and in a manner that the client* can tolerate without client or therapist becoming overanxious.

f. *LEADERSHIP:* The therapist must accept a leadership role in relationship to the ego strength (ability to cope) of the client and/or his family. The golden rule is *DO for a member that which he cannot do for himself -- and NO MORE!!*

This relationship should not be the end goal of therapy but rather the medium in which therapeutic change is fostered. Thus:

1) If a therapist senses a consistent negative feeling toward him from the client or vice versa, he must stop and examine this feeling *with the client.* Therapeutic progress is impossible, at least towards the mutually agreed upon therapeutic goals, in a persisting negative atmosphere.

2) Similarly, if a client becomes so enamored of the therapist that the therapy becomes diverted from its goals to a struggle in and outside therapeutic sessions to elicit reciprocal feelings from the therapist -- this too, if persistent, requires gentle but firm and direct discussion.

3) *Dealing with the substantive content* of a person's life *will not lead to productive change* unless a positive relationship is present or reestablished. Content discussed in the distant testing atmosphere of early therapy or while negative feelings are rampant will require review in a positive atmosphere for productive therapeutic work and change to be accomplished.

4) Once a strong relationship is established, the *therapist's approval* becomes a *positive* social *reward* and *disapproval* becomes *punishment.* Used in this way the relationship serves the additional critical purpose of *therapeutic leverage* to accomplish change in the direction of desired goals. Behavior therapists utilize this intra-therapy conditioning (reward-punishment) in *planned creative ways* to alter behavior.

NOTE:

The therapist who is emotionless, always in control, nonrevealing of his own particular personality, and relatively silent, fosters fantasies; encourages magical expectations of cure; sets an inappropriate unnatural example of human interpersonal interaction; stirs anxiety; fosters regression; dissolves defensive operations; conveys the message that the patient must largely work on his own. All these are useful with well-put-together patients, with no acute distress, functioning productively, who seek therapy due to chronic existential discontent, i.e., with candidates suitable for psychoanalysis or psychoanalytic therapy.

This relatively reserved, passive, nonrevealing approach is specifically *contraindicated* in other therapies especially crisis intervention and psychotherapy with borderline and acutely irresponsible clients.

2. *PRESENT CENTERED:* What needs are not being met *now* (in the present)? Search continually for real feelings of discomfort (pain) rather than imposing therapist perceptions on the client or passively going along with a client's implicit or explicit discomfort without truly concurring with them. A naivete which assumes little or nothing regarding the client's discomfort is called for, e.g., a client presenting with eleven years of chronic pain and invalidism is frequently ambivalent about achieving a pain-free existence despite his protestations to the contrary. In such a case the real discomfort may be fear of having no pain.

   The wise therapist will benevolently, yet skeptically pursue in detail the nature of the discomfort exhibited by the client. *Many therapists are too timid in exploring feelings.* Human beings are surprisingly rugged. Press and even confront when necessary until there is consonnance between what is expressed and what is felt. *Remember, tears are the client's responsibility.*

3. *FEEDBACK:* The therapist at the *onset* and *throughout* therapy should make sure that the client understands any techniques used, the participation expected of a "good client," and the expected outcome of the therapy.

   Frequent review of what you (the therapist) have been hearing and *feeling*, and how that fits into the client's life when given as explicit feedback produces several benefits.

   a. The client sees you as involved, listening, formulating, empathizing, and working just as you expect him to be.

   b. You ensure that the therapeutic partnership is working on the same set of data since...

   c. The client can correct and add new data in the midst of, and following each feedback exchange.

4. *FORMULATION* (Insight): A statement about why things are the way they are *now*. This is necessary since it allows both the therapist and the client to have a structure on which to place the "Facts" of a member's life. It offers an explanatory model for life events, feelings, and interactions; thus, one can "understand" the present and plan for the future. The specific explanation used seems to be less relevant than the conviction the therapist displays in it. It is also best

when the client develops the insight since the words and concepts used must be within the conceptual grasp of the client, taking into consideration his intellectual capacity and cultural set toward the explanation of emotions and behavior.

5. *ALTERNATIVES:* Generate possible solutions to the problem being experienced. Be creative and don't evaluate solutions before they are generated. Use brainstorming and free association. Often, the client is imposing limits on himself that perpetuate the status quo.

   Once possible alternatives have been generated, eliminate those which the client cannot effect since his behavior change will not produce the desired result if it involves someone else who is not part of the process.

   Next, the client must select an alternative that he can achieve and is willing to risk.

   The therapist must work to foster honest and critical self-observation on the part of the patient while continuously standing off and looking at himself, the therapist. This includes both positive and negative observations. These should be made explicit in the therapy if an attitude or feeling has become persistent within the therapist; especially if the therapy seems to be at an impasse. This will be particularly useful with patients who have difficulty with honest introspection, who might benefit from this type of honest, healthy role modeling.

   Most patients suffer from low self-esteem. Any successful therapy involves maneuvers that hopefully will induce more positive self-concept. Important among these is the necessity of encouraging behaviors that will lead to success with or without the therapist manipulating the environment to insure them.

   Remember, that many people would rather keep their hopeless, helpless self-concept than risk the pain of failing to maintain a positive one.

   Look carefully for the last best period of life performance. Get the best idea possible of the strengths available at that point. Try to get the patient to recapture and work from these strengths rather than spending much time on exploration of the various weaknesses and symptoms of the decompensation syndrome.

6. *IMPLEMENTATION* (risking or behavior change): Explicitly expect behavioral changes in the desired direction outside the therapeutic situation consonant with the therapeutic goals mutually arrived at by both client and therapist.

Insight into continuing chaotic behavior or accommodation to a cruel reality are perversions of therapy's true purpose which is to assist people in their attempts to alter their world intrapersonally and interpersonally with benefit to all they encounter. While insight can help to produce behavioral change in the hoped-for direction -- behavioral change must be fostered by the therapist with or without insight by asking the patient to "fake it" or "pretend" the new behavior despite his or her lack of inner conviction. Example: a housewife acts *as if* she is competent and lovable enough to demand the respect of husband and children, risking rejection and even their loss. This "artificial" behavioral change can result in permanent behavioral changes, that is, new learning if the new behavior is positively rewarded by the therapist and the environment (family). Insight, in fact, frequently comes subsequent to behavioral change.

People distressed by symptoms will present seeking relief. They will tolerate a wide variety of therapeutic measures from psychoanalysis to drugs and electroshock despite the attendant cost in time, effort, inconvenience, money, and side effects to obtain relief. However, despite conscious awareness of an often grossly dissatisfying life situation, they will resist making behavioral changes in relation to significant people in their lives (spouse, children, lover, employer, friends).

The courageous therapist will *resist resorting to symptomatic therapy alone* and will require that the client "risk" changes to accomplish a more self-respecting, need-satisfying existence.

Elicit emotional release when ever possible through explicit empathy as well as cognitive explanation, that is, interpretation on the basis of the formulation. This increases the probability of behavioral change, that is, new learning (intellectual insight arrived at within an atmosphere of emotional release is gratifying and tension-relieving, which itself induces appreciation and cementing of the therapeutic relationship). It also makes the new behavior more relevant and meaningful to the client.

Managing specific emotions: anger, depression, jealousy, guilt, joy, pride, etc., call for similar management. The therapist should evoke the affect and its associated content assertively, empathically, warmly, nonjudgmentally, using therapist approval to reward the sharing of these feelings.

CAUTIONS WORTH NOTING:

a. *ANXIETY:* The therapist must be sensitive to the client's anxiety and titrate it within optimal limits for therapeutic work. If anxiety is too low there will be no involvement in therapeutic work and behavior will not alter. If anxiety is too high, it will be disruptive and no learning will take place.

Anxiety is evidence that the ego is under stress and, if excessive, the patient will fight, flee,or fall apart. Unlike anxiety, depression, guilt, jealousy, etc., are coping techniques as well as emotions and need to be fully explored, as does any symptom,despite the discomfort associated with doing so.

b. Beyond a certain point, *release of emotion* (catharsis) no longer is relieving and productive but rather *becomes a mechanism to avoid engaging in productive problem solving* with the therapist by "wallowing" in emotion. Kind, firm confrontation **is** called for in this situation.

c. *RESISTANCE:* Resistance to experiencing new behaviors that involves sharing an emotion, e.g., grief, or anger, is characteristic of many emotional problems. In general, the therapist should first deal with this resistance. Usually, this involves exploration of the fears (less than conscious, "catastrophic expectation") involved in experiencing affect, e.g., losing control, going crazy, killing, dying, losing loved ones, and so forth.

Resistance to change consistently obstructs the therapist's best efforts. The discomfort of examining long-term solutions to old developmental problems, force of habit, and fear of the consequences of new behaviors are some reasons for the difficulty.

Two forces on the side of therapeutic work are (a) *Pain*, currently experienced by the patient for which he seeks relief: thus, he can be influenced to risk new behaviors in the hope of relief, and (b) the *Positive Relationship* used as a lever by the therapist. In general, patients will take the minimal risks necessary in and out of therapy to satisfy the therapist yet expect symptom relief nonetheless. Patients will soon adjust to a particular therapeutic style or technique when progress has halted. Despite one's best efforts at exploration of the resistance, the fears and so forth often produce enough of an intratherapy minicrisis to remove the therapy logjam. Bringing in spouse for some cojoint sessions, or asking a colleague to consult, becoming more active or much less active in the therapy, or changing your conditions (contract) for participating are some examples.

7. *CONTINGENCIES:* Help the client consider potential consequences of success and factors that might produce *failure.* This helps reduce the potential for rationalization and surprise while allowing the client to begin contingency

planning.

It is very important for the client to realistically consider ways to fail. Self-concept and self-esteem are both negatively affected by continued unexpected failure. Their impact is greatly reduced when they are seen as reasonable obstacles to be allowed for.

The need to plan for success and to explore success in subsequent sessions reflects the need to support the new skills and emotions developing in the client with adequate concept formation (attributions of meaning). Planning for the contingencies of success often helps clients sustain momentum and control beyond the original problem area.

New client behavior also produces reactions in others that must be interpreted and managed by the client in the absence of the supportive therapist. The therapist can greatly extend his support and positive influence by insisting that the client explore and prepare for these contingencies.

MODULE 7: THE SIX SELVES

FOCUS

In this module, participants will attempt to depict the six aspects of themselves: their physical, emotional, spiritual, intellectual, public, and private selves. Consideration of each aspect will provide a more thorough understanding of the total self. This understanding can be helpful in the therapeutic process.

Participants will also be able to compare their self-perceptions with the perceptions others have of them. This will help them develop self-awareness and an understanding of how others perceive them.

LEARNING OBJECTIVES

At the end of this module, each participant will be able to:

- Name the six aspects of the self
- Identify three areas in which self-perception is either the same as others' perceptions of him or her or is different from these
- Describe two advantages of being aware of unadmitted aspects of a client's self

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MODULE 7: THE SIX SELVES

ACTIVITY: THE SIX SELVES

Goal

This activity is designed to help participants think about the six aspects of the individual -- the physical, intellectual, emotional, spiritual, public, and private -- and then make representations of these selves.

Description

Think about the six aspects of yourself and make representations of these using crayons and newsprint. The representations may be abstract designs, drawings, or impressions: anything that you think depicts each of your selves. Artistic talent is unimportant; relax and enjoy experimenting with the medium.

Comments

SMALL-GROUP DISCUSSION

Goal

This discussion is designed to help participants understand their six selves and any differences between their own and others' perceptions of these selves.

Description

In the small groups, discuss your perception of your six selves. Then discuss with other group members their perceptions of you based on your actions. Examine any discrepancy between your description and others' perceptions.

Comments

MODULE 8: COUNSELING PRACTICUM

FOCUS

In Module 8, participants will be able to practice counseling skills and to give and receive feedback on the use of these skills.

LEARNING OBJECTIVES

At the end of this module, the participants will be able to:

- Identify two areas in which they can improve their counseling skills
- Cite two strengths they have as counselors
- Identify at least one area of strength for each member of their practicum group
- Give constructive feedback (according to the guidelines in this module) to members of their practicum group, including at least one specific suggestion to each person on an improvement that could be made in his or her counseling technique
- Define the seven steps of behavior change citing specific counseling strategies that might be used to accomplish each step
- Demonstrate the ability to apply the principles of behavior change in the individual counseling situation

MODULE 8: COUNSELING PRACTICUM

ACTIVITY: INDIVIDUAL COUNSELING PRACTICUM AND GROUP DISCUSSIONS

Goal

This activity is designed to give participants practice in using counseling skills and an opportunity to give and receive feedback on the use of these skills.

Description

Members of static groups work together in this activity. One member assumes the role of counselor and another that of client; the rest act as process observers. Every member will be able to act as client, counselor, and observer.

During this activity, examine the counseling process in terms of the principles of behavior change discussed earlier. In your role as observer, take careful notes so that you can give feedback to the participants. Study the feedback roles that follow before making comments.

After each counseling experience, all group members discuss that experience before beginning the next session.

Comments

FEEDBACK*

FEEDBACK is a way of helping another person consider changing his behavior. It is a communication to a person (or to a group) which gives that person (or group) *information about how he affects others* (or how the group is affecting one of its members).

As in a guided missile system, "feedback" helps a person keep his behavior "on target" and thus better achieve his goals.

SOME CRITERIA FOR USEFUL FEEDBACK

1. It is *descriptive rather than evaluative.* By describing one's own reaction to another's behavior (a specific bit), it leaves the other free to use it or not use it, as he sees fit. BY AVOIDING EVALUATING LANGUAGE, it reduces the need for the individual to react defensively (learning is well nigh impossible when one's defenses are up).

2. *It is specific* rather than general. To be told that one is "domineering" will probably not be as useful as to be told that "just now when we were deciding the issue, I felt that you did not listen to what others said and that you were expecting me either to accept your point of view or face attack from you." Speak to specific data.

3. *It takes into account the needs* of both the receiver and the giver of it. For feedback can be destructive when it serves only our own needs as giver and fails to consider the needs of the person on the receiving end.

4. *It is directed toward behavior which the receiver can do something about.* Frustration is only increased when a person is reminded of some shortcoming over which he has no control. Helpful level.

5. *It is solicited, rather than imposed.* Feedback is most useful when the receiver himself has formulated the kind of question which those observing can answer and this places a responsibility for openness on both.

6. *It is well-timed.* In general, feedback is most useful at the *earliest opportunity after the given behavior* -- depending, of course, on the person's (or group's) readiness to hear it, support available from others, etc.

7. *It is checked* to insure clear communication. One way of doing this is to have the receiver try to rephrase the feedback he has received to see if it corresponds to what the sender has in mind. Also, both giver and receiver need opportunity to check with others in the group the accuracy of the feedback. Is this one man's impression

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* Adapted from "Feedback and the Helping Relationship." Cyril Mill and Lawrence Porter, Editors. *1972 Reading Book,* NTL Institute for Applied Behavioral Sciences, Associated with the National Education Association.

or is it an impression shared by others? As many reactions as possible. Check with others in the group.

8. Speak for yourself, for only you know how *you* feel.

FEEDBACK, then, is a way of giving help; it is a corrective mechanism for the person who wants to learn how well his behavior matches his intentions.

MODULE 9: COGNITIVE AND AFFECTIVE CLOSURE

FOCUS

In this module, participants will review the material presented in Unit B and preview the information in Unit C. Module 9 includes: (1) a review of the seven principles of behavior change; (2) cognitive and affective closure of the static groups; (3) the posttest; (4) a review of the major concepts presented in Unit B and a discussion of how participants can use these in their work situations and personal lives; (5) an overview of Unit C and an explanation of the written homework assignment for that unit; and (6) an opportunity for each member of the training group to express feelings to any other member.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Demonstrate an increase in knowledge according to the seven cognitive objectives for Unit B (See Training Objectives, p. 3)
- Demonstrate a statistically significant attitudinal change in at least 75 percent of four designated areas (See Training Objectives)
- Demonstrate an acceptable level of skill in three areas as judged by the trainers (See Training Objectives)
- Identify at least two personal imprints and their affects on current situations and relationships
- Identify at least two ways to improve counseling skills or to use the seven principles of behavior change
- Express the concepts presented in Unit B and how these concepts will affect behavior in the work situation
- Express a basic understanding of the content and process of Unit C
- Express their feelings at the end of Unit B to another member of the training community or state that they are unable to express such feelings

MODULE 9: COGNITIVE AND AFFECTIVE CLOSURE

ACTIVITY: REVIEW OF THE SEVEN PRINCIPLES OF BEHAVIOR CHANGE

Goal

This activity is designed to provide a review of the seven principles of behavior change and their use in the counseling situation.

Description

While watching the videotape presentation, identify where and when the seven principles of behavior change were used by the therapist. Note these on the Film Viewing Worksheet for a discussion in the static groups.

Comments

SEVEN PRINCIPLES OF BEHAVIOR CHANGE
FILM VIEWING WORKSHEET

1. Establish relationship (explicit, empathic)		
2. Focus on here-and-now pain		
3. Opening feedback channels		
4. Formulation of problem		
5. Explore options/alternatives		
6. Risk/integration		
7. Action plan (explore contingencies]		

ACTIVITY: LARGE-GROUP AFFECTIVE CLOSURE

Goal

This activity is designed to provide affective closure to the training.

Description

Form a circle by placing your arms around one another or by touching one another. Share positive personal feelings about other individuals and about the learning experience with the rest of the group.

Comments

STATIC GROUPS CLOSURE

Goal

This activity is designed to provide cognitive and affective closure of the training process.

Description

In your static group, discuss the activity just completed. Then give feedback to others about their personal growth in improved knowledge of the seven principles. Accept feedback about yourself.

Comments

POSTTEST AND EVALUATION

After completing the posttest, evaluate the training by responding to the following questions and statements.

1. What did you find least helpful in the training experience?

2. What did you find most helpful?

3. Write one positive and one negative feedback statement to each member of the staff.

4. Do you have any other comment about the training?

REVIEW OF UNIT B, OVERVIEW OF UNIT C

During the review of Unit B, the group members will discuss the concepts presented during the training and the implications of these to the work situation. An overview of Unit C will be presented.

Assignment

The homework assignment is to detail an answer to: *"What happens to a client who goes through your program?" Imagine yourself as the client, noting everything that happens to you.*

ADDITIONAL RESOURCE MATERIAL

ROADBLOCKS TO COMMUNICATION

Prepared

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ROADBLOCKS TO COMMUNICATION

1. *ORDERING, DIRECTING, COMMANDING.* Telling the other person to do something...giving him an order or command.

These messages tell another that his feelings or needs are not important; he must comply with what you feel or need. "I don't care what you want to do, get those forms filled out right now!" They communicate unacceptance of the other person as he is at the moment..."Stop that talking!" They produce fear of your power. The other person hears a threat of getting by someone bigger or stronger than he. "Finish that food or I'll feed it to you!" These messages engender feelings of resentment or anger, frequently causing the other person to express hostility, fight back, resist, or test your will. They can communicate that you don't trust the other person's judgement or competence..."Don't touch that T.V. set!"

2. *WARNING, ADMONISHING, THREATENING.* Telling the other person what consequences will occur if he does something; alluding to the use of your power.

These messages can make a person fearful and submissive..."If you are late for your appointment you'll be sorry." They evoke resentment and hostility the same way that ordering, directing, and commanding do..."If you don't shape up you can't go home this weekend!" They communicate that you have no respect for the other person's needs or wishes..."If you don't quit daydreaming I'm going to kick you off the team!" People sometimes respond to warnings or threats by feeling or saying "I don't care what happens, I still feel this way." These messages also invite the other person to test your firmness, to do something that they have been warned against just to see if the consequences promised actually happen.

3. *MORALIZING, PREACHING, OBLIGING*...Telling another person what he should or ought do.

Such messages bring to bear on the other person the power of external authority, duty or obligation. People frequently respond to such "shoulds," "oughts," and "musts" by resisting and defending their own postures even more strongly. These messages may make a person feel that you do not trust his judgement... that he had better accept what "others" deem right... "You'd better be good." They may cause feelings of guilt in the other

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person...that he is "bad" ..."You shouldn't act that way." They may make the other person feel that you do not trust his validation of others; values and ideas..."you must respect your elders."

4. *ADVISING, GIVING SUGGESTIONS OR SOLUTIONS*...Telling the other person how to solve his problems.

Such messages are often felt by the other person as evidence that you don't have confidence in his judgement or ability to find his own solution. They may cause him to become dependent on you and stop thinking for himself..."If your neighbor does that again, call the police." Sometimes other people strongly resent the attitude of superiority that advising or suggesting infers, or feel inferior and think "Why didn't I think of that?" or "You always know better than I what to do." Advice can make the other person feel that you haven't understood him at all... "You can kick the smoking habit if you just try harder."

5. *PERSUADING WITH LOGIC, ARGUING, INSTRUCTING, LECTURING*... Trying to influence the other person with facts, counterarguments, logic, information, or your own opinions.

An especially difficult task for those of us in the helping professions is to stop instructing or using logical arguments when there is a problem of unmet needs. At these times "teaching" often makes the other person feel you are making him look inferior, subordinate, inadequate..."The facts are that heavy use of marijuana leads to loss of immediate recall." Logic and facts often make the other person defensive and resentful. People seldom like to be shown that they are wrong. Consequently, they defend their positions to the bitter end. In addition, people tend to view our lectures as harangues and they tune out quickly. People often resort to desperate measures to discount our "facts," such as: "You are too old to know what is going on," or "You're a square." They may even ignore facts and assume an "I don't care" attitude.

6. *JUDGING, CRITICIZING, DISAGREEING, BLAMING*...Making negative judgements or evaluations of another person

These messages, probably more than any of the others make people feel inadequate, inferior, stupid, unworthy, bad. Self-concepts get shaped by our judgements and evaluations. As we judge a person, so will he judge himself. "It's your own fault. If you weren't so lazy you would get a job and be able to pay your bills instead of whining about it." The other person feels: "I'm a no-good bum." Negative criticism evokes counter criticism... "You're not so hot yourself," or "Since when were you perfect?"

Evaluation strongly influences people to keep their feelings to themselves. They quickly learn that it isn't safe to talk about much of anything, to speak only when spoken to, and then noncommittally. People hate to be judged negatively and respond defensively simply to protect their own self-images. Often they become angry and feel hatred toward the evaluator even if the evaluation is correct. Probably the only message more devastating than negative evaluation is frequent negative evaluation.

7. *PRAISING, AGREEING, EVALUATING POSITIVELY, APPROVING*...Offering a positive evaluation or judgement.

Contrary to the common belief that praise is always beneficial to the recipient, it often has a very negative effect. A positive evaluation that does not fit the other person's self-image may evoke hostility..."I'm not a good swimmer!" or "My hair is not pretty this way, I hate my hair!" People infer that if we can judge them positively, we can as easily judge them negatively some other time. Also, the absence of praise in a situation where praise is frequently used may be interpreted as criticism. Praise given to one person may be interpreted by others as a negative evaluation of them - that comparatively, they are not as good. Thus the use of praise tends to promote competition for recognition, to score "brownie points." Praise is often felt to be manipulative, a subtle way of influencing the other person to do what you want him to do. He feels: "You're just saying that so I'll work harder." Praise frequently embarrasses people, especially when given in front of other people. If you praise you may find that other people become so dependent upon it that they cannot function without constant approval from you.

8. *NAME-CALLING, RIDICULING, SHAMING*...Making the other person feel foolish, stereotyping or categorizing him.

Such messages have a devastating effect upon the self-image of another person. They make him feel unworthy, bad, unloved. The most frequent response of people to such messages is to give one back to you: "Boy, what a grouch!" or "Look who's calling me stupid." Such messages when you are attempting to influence another person are not likely to cause him to examine himself realistically. Instead, he may focus on your unfair message and excuse himself..."I am not inconsiderate. You expect too much!"

9. *INTERPRETING, ANALYZING, DIAGNOSING*...Telling a person what his motives are or analyzing why he is doing or saying something; communicating that you have him figured out or have him diagnosed.

Such messages can be threatening to other people. If the analysis is accurate the person may feel embarrassed at being "exposed"..."You are just doing that to get attention." When the analysis is wrong, as it most often is, the other person will become angry at being unjustly accused. We often communicate an attitude of superiority to other people when we analyze and diagnose, an attitude which the other person resents..."You think you know so much." The "I know why" and "I can see through you" messages tend to cut off further communication from the other person and he learns to refrain from sharing his feelings.

10. *REASSURING, SYMPATHIZING, CONSOLING, SUPPORTING* ...Trying to make the other person feel better, talking him out of his feelings, trying to make his feelings go away, denying the strength of his feelings.

These messages are not as helpful as most of us feel they are. To reassure a person when he is feeling disturbed about something may simply convince him that you don't understand him... "You wouldn't say that if you knew how scared I am." We often reassure and console because we are not comfortable with other people's strong feelings. Such messages tell a person that you want him to stop feeling that way..."Don't feel bad; things always turn out for the best." People can easily see through reassurances as an attempt to change them..."You're just saying that to make me feel better." Discounting or sympathizing often stops further communication because the other person senses you want him to stop feeling the way he does.

11. *PROBING, QUESTIONING, INTERROGATING* ...Trying to find reasons, motives, causes; searching for more information to help you solve the problem.

To ask questions may convey your lack of trust, your suspicion or doubt..."Did you wash your hands like I told you to?" People also see through some questions as attempts to "get them out on a limb" only to have it sawed off..."How much beer do you drink a day?" "Two quarts?" "Well, no wonder you are such a mess." People often feel threatened by questions, especially when they don't understand why they are being questioned. Note how often people answer your question with a question of their own..."Why are you asking that?" or "What are you driving at?" Another "safe" response to questions is the ubiquitous "I don't know." If you question a person who is sharing a problem with you he may suspect that you are gathering data to solve his problem for him, rather than letting him find his own solution..."When did you start feeling this way?" "Does it have anything to do with what is happening at home?" People generally do not want us to come up with answers to their problems. They say: "Adults (read: Ministers, Counselors, Coaches, Leaders, Friends) are all

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alike. If I tell them my problems they end up telling me what to do." When you ask a question of someone who is talking about a problem, each question limits the person's freedom to talk about whatever he wants to...in a sense each question dictates his next message. If you ask "When did you notice this feeling?" you are telling the person to talk only about the onset of the feeling and nothing else. This is why being cross-examined by a lawyer is so terribly uncomfortable. You feel you must tell your story exactly as demanded by his questions. Interrogating another's communication is not a good way to facilitate problem solving on his part.

12. *WITHDRAWING, DISTRACTING, HUMORING* ...Trying to get the other person away from the problem; withdrawing from the problem yourself; distracting the person, kidding him out of his feelings, pushing the problem aside.

Such messages can communicate to the other person that you are not interested in him, don't respect his feelings, or are downright rejecting him..."Boy, it's a good thing the President doesn't have problems as serious as yours." People are generally quite serious and intent when they need to talk about something. When you respond with kidding you can make them feel hurt, rejected, belittled. Putting people off or diverting their feelings may for the moment appear successful, but a person's feelings do not always go away. They often crop up later. Problems put off are seldom problems solved. People want to be heard and understood respectfully. If their listeners brush them aside they soon learn to take their important feelings and problems elsewhere.

ALL OF THE PREVIOUS TWELVE TYPES OF RESPONSES IN ONE WAY OR ANOTHER COMMUNICATE NON-ACCEPTANCE.

ROLLO MAY -- EXISTENCE*

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* Adapted from Rollo May, et al. Eds. *Existence: A New Dimension -- Psychiatry and Psychology*; New York: Basic Books, 1958.

ROLLO MAY — EXISTENCE*

Can we be sure that we are seeing the patient as he really is, knowing him in his own reality, or are we seeing merely a projection of our own theories about him? Are the unconscious ideas of the patient more often the conscious theories of the therapist?

Many psychoanalysts, working separately, became dissatisfied with standard techniques — lacked clear understanding of why cures did or did not occur, or what actually was happening in the patient's existence. They had grave doubts about Freudian theory of man, sought to understand individual's neuroses or psychoses, or crisis situation, not as deviations from preconceived theoretical framework, but as deviations in the structure of that particular patient's existence — his OWN disruption.

Existentialism and psychoanalysis arose out of the same cultural situation; both tried to analyze anxiety, despair, alienation of man from himself and his society.

Freud described the neurotic personality of the late 19th century as one suffering from fragmentation — repression of instinctual drives, blocking off of awareness, loss of autonomy, weakness and passivity of the ego plus various neurotic symptoms resulting from this fragmentation.

Kierkegaard analyzed not only anxiety but especially the depression and despair which result from the individual's self-estrangement.

Nietzsche said the disease of contemporary man is that his soul had gone stale, he had a smell of failure — European man's leveling and dimunition were the greatest dangers. He described how blocked instinctual powers turn, within the individual, into resentment, self-hatred, hostility and aggression.

The chief characteristic of the last half of the 19th century was the fragmentation of man's personality, symptomatic of the emotional, psychological, and spiritual disintegration occurring in the culture and in the individual. Accompanied by developing industrialism as both cause and effect, rationality was being reduced to a new kind of technique, not a part of total man. The sciences which pertained to man went off in separate and unrelated-to-each-other directions — nor were they related to a clear and consistent idea of man. As the culture grew more compartmentalized, radical repression within the individual grew.

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Freud developed techniques for understanding and perhaps curing this fragmented personality — he did not see until much later that the individual's neurotic illness was only one side of disintegrating forces which affected all of society.

Kierkegaard foresaw the results of this disintegration upon the inner emotional and spiritual life of the individual — anxiety, loneliness, estrangement of one man from another, and finally the condition that would lead to ultimate despair — man's alienation from himself.

Nietzsche said "We live in a period of atoms — of atomic chaos" — he foresaw collectivism and its eventual destruction of everything.

Kierkegaard and Nietzsche did not underestimate the importance of specific psychological analysis, which was Freud's interest, but they were much more concerned with understanding MAN AS THE BEING WHO REPRESSES — who surrenders self-awareness as a protection against reality and then suffers neurotic consequences.

Kierkegaard tried to understand and disclose human existence. He wrote on self-consciousness, inner conflicts, loss of the self, and psychosomatic disturbance. His question was, "How can you become an individual?" The individual was being swallowed up by rationalism, man's economic objectification, soft and vapid religion. He said our objectivity is impossible, undesirable and immoral - we are so involved in each other and the world that we cannot be content to view truth disinterestedly.

Every question is the "question for the single one" — the alive and self-aware individual; if we don't start with him, we shall spawn, with all our technical prowess, a collectivism of robots who will end up not just in emptiness but in self-destructive despair.

Nietzsche's "will to power" implied the self-realization of the individual in the fullest sense — the courageous living out of his potentialities in his own particular existence. Man should cease allowing his existence to be a thoughtless accident. Individuality, worth and dignity are not given us as data by nature, but are given or assigned to us as a task which we ourselves must solve. He strove to unmask self-deception.

Descriptive Phenomenology: careful and accurate description of the subjective experience of an individual with an effort to empathize as closely as possible with his experiences, through collecting reports from recovered patients describing their experiences. However, this proved inadequate and led to

Genetic-structural Phenomenology: an attempt to define the basic disturbance from which one could deduce the whole content of consciousness and the symptoms of the patient. In melancholics it was found that time is not experienced as a propulsive force, the future is blocked, his attention is directed toward the past, the present is experienced as stagnating. In the compulsive neurotic it was found that he was warding off symptoms, fighting ugly, dirty, repulsive things. His world was devoid of friendly forms — all objects were infected with decay — he was fighting against a background of disgust and destruction.

Categorical Phenomenology:

1. *Temporality:* of crucial importance. For the normal individual, time is experienced as a flowing of life — as spontaneous, living energy, as flowing with a certain speed, and it fluctuates throughout human life, much more slowly for the young child than for the adult — seems to increase in speed with growing and aging.

Time flows slowly when one experiences anxiety, boredom, grief or sorrow — more rapidly with joy, happiness.

The activist fills up every minute with as much activity as possible; lackadaisical individual pays no attention to time; the contemplative person is absorbed with his quiet vision of the universe and the silent growing up of his inmost self; the pseudo mystic, striving to transcend common time with drug experiences in which he feels he is living whole years in a few hours; for some, time is boredom — one must kill it; the compulsive neurotic wastes his time by endless procrastination, then suddenly becomes stingy with it; the depressive arrests time and it flows backwards; some schizophrenics feel as if time were fixed at the present moment (delusion of immortality); manics and seniles (unless depressed) experience increased speed of time. For the manic and some other psychopaths nothing is projected into the future — it is empty; for the depressed the future is inaccessible and blocked — very painful; in some paranoids the past is very inconstant and changing. All these people have different subjective experiences of time. Distortions of the feeling of time result in the distortions of the meaning of life — ex. — when future is empty or blocked life loses its meaning.

There is also "world time" — our personal time must be inserted into the social, historical, and cosmic time. Schizoids and some others live more in their own personal time than in world time. The melancholic is aware of both forms of time, but his personal time flows much more slowly than world time.

2. *Spatiality:* one individual strives to conquer space or explore it, another to keep and defend it, another to organize and utilize it, another to measure it. Some make themselves broad and fill up space, others constrict themselves and have narrow life spaces; one can be rooted in a place or uprooted and wandering; some make real or fantasy escapes. Agoraphobia or claustrophobia patients have very disturbed experiences of space.

Oriented Space: dimensions, distances, planes, boundaries. The major feature is that it has a center of reference that is mobile — the body. There is an infinite variety of oriented spaces, apart from those of our daily experiences: many schizophrenics have anomalies of visual perception — some need inordinate degrees of symmetry, some seem to have added a 4th dimension from which they are watched by invisible observers. The *vertical axis* is the basic axis of human existence to which our most vital experiences are related — life is felt as a constant movement upward or downward. *Distance* also has many implications — the neurotic puts distance between himself and his life goal, the world, his fellow man.

Attuned Space: spatial experience determined by one's feeling tone or emotional pitch, a quality of space in accord with one's mood. One's inside space may be one of fullness or emptiness, expanding or constricting. Love may make one feel close to the object of love, even though there is real distance between. Happiness expands the attuned space, sorrow constricts it, despair makes it empty. Schizophrenics lose attuned space progressively or suddenly, organic brain patients suffer deterioration of oriented space, manic depressives and schizophrenics experience more deterioration of attuned space. In experimental psychoses, there are distortions of both form and space.

Clear Space: horizon, perspective, distinctness, experienced distance — missing in many neurotics and schizophrenics.

Free Space: between individuals — it enables the fortuitous or unforeseen to happen, allows an emotionally neutral space.

Dark Space: obscurity or fog of horizon and perspective -- black, thick, gloomy; since the experienced distance disappears, . . . vital space is narrowed and desocialized. It surrounds the individual and even penetrates his body; it is the substratum of delusions of persecution. The normal opposite of delusions of persecution is the feeling of easiness of life, intimately connected with the experiences of distance and life amplitude.

Luminous Space: Subject is blinded by an intensive light — underlies mystical or ecstatic experiences.

Flight distance: at which an animal takes flight from a man.

Critical distance: at which the animal turns from flight to counterattack — much shorter than flight distance.

3. *Casuality:* includes determinism, chance and intentionality. Melancholic — deterministic; man - chance - complete irresponsibility, where everything happens through pure chance.

4. *Materiality* (substance): Consistency (fluid, soft, hard), tension, shock, heaviness, lightness, hot and cold, light, color, (depressed -- black, manic -- rose) etc.: elements of fire, air, water, earth in patient's subjective worlds.

AIM OF PHENOMENOLOGY: To reconstruct the inner world of experience of the subject -- how he experiences time, space, causality, materiality, and how each relates to the others and to the total inner world. Phen. ignores psychic and physical causality, in contrast to psychoanalysis whose orientation is historical and causal.

Existential philosophy: What is man's most immediate experience -- his own existence. Existence is very different for inanimate objects and for human beings -- "Danein" designates the mode of existence peculiar to humans. Man is not a ready-made being -- he will become what he makes of himself and nothing more; he has the freedom to make choices, primarily the freedom to choose between an inauthentic and an authentic mode of existence.

Inauthentic: man who lives under the tyranny of the crowd, the anonymous collectivity.

Authentic: Man who assumes the responsibility of his own existence. In order to pass from inauthentic to authentic existence, a man has to suffer the ordeal of despair and "existential anxiety" -- the anxiety of a man facing the limits of his existence with its fullest implications -- death, nothingness, (Kierkegaard).

Existential philosophy inspired existential analysis.

Existential psychotherapy: Application of certain existentialist concepts to psychotherapy without regard to phenomenology and psychoanalysis -- no standard system or method.

1. Existential neurosis: illness arising not so much from repressed trauma, a weak ego, or life stress, but rather from the individual's inability to see meaning in life, so that he lives an inauthentic life. He must find meaning in life.

2. Encounter (rather than transference): the decisive inner experience resulting from the meeting of two individuals, experienced by one and sometimes both individuals -- not identification. If the personality of one of them is changed, it means NOT that he copies a model, but that the model serves as a catalyst in whose presence he comes to realize his latent and best abilities, and to shape his own self.

3. Kairos: The critical point in a person's illness when he is inwardly ready for a certain kind of intervention.

Existential analysis: Operates within a larger frame of reference than does phenomenology:

1. Existential analysis does not restrict itself to the investigation of states of consciousness but is concerned with the individual's entire structure of existence.

2. In phenomenology the individual's inner world is unified; in existential analysis the individual may live in two or more sometimes conflicting worlds.

3. Phenomenology is interested only in the immediate subjective worlds of experience; existential analysis strives to reconstruct the development and changes of the individual's world or conflicting worlds; implies a biographic investigation.

Modes: Classical psychology assumes continuity and sameness in the subject; existential analysis states that the "self" changes according to the various forms of existential modes:

1. Dual: mode of intimacy (mother-child, lover-beloved, etc.). Space becomes paradoxically infinite and all-near; distance and proximity are transcended by a spatial mode which has the same relation to space that eternity does to time; the moment coincides with eternity, excludes transcient duration. This inner home of love (Heimat), which transcends space and in which the moment and eternity fuse, forms the core of the normal existential experience.

2. Plural: mode of formal relationships, competition, struggle, coexistence of "one and the other."

3. Singular: mode of man's relationships with himself, including his body. Psychoanalysis deals with narcissism, self-punitive and self-destructive behavior -- existential analysis concept is much broader and includes a wide range of intrapsychic relationships. (Ex.: Inner conflict is seen as a variety of singular mode patterned on the model of the plural mode; autism is not only a lack of relations to one's fellow men but also a specific mode of relationship to oneself.)

4. Anonymous: mode of the individual living and acting in an anonymous collectivity -- used as a means of escaping or fighting.

Aims: To investigate the life history of the patient, but not to try to explain this life history according to the teachings of any particular school, or according to categories; to understand this life history as modifications of the total structure of the patient's being in the world; to understand man by cutting below the cleavage between subject and object. Man is not an object to be controlled, analyzed, understood as a "thinking" being, but rather as an existing, experiencing organism. Existence refers to coming into being -- BECOMING. Crucial question: what is abstractly true and what is existentially real.

Therapeutic implications: existential analyst seemingly performs like an ordinary psychiatrist -- studies everything about the patient; reconstructs his biography. However, he observes and classifies within the existential framework, achieving much deeper understanding. Errors in temporality, spatiality, etc., can be reconsidered and readjusted. Reconstruction of the subjective world of the patient is more than an academic exercise; he is not inert material; he reacts to the kind of approach. If he is objectively, intellectually, scientifically studied, he may feel that his inner self is being disregarded.

Try to discover what keeps the patient from accepting freely his potentialities.

Emphasize the present and presence -- the relationship of the therapist and patient is a real one -- therapist must see the patient as someone to be understood rather than an object to be analyzed -- "the patient needs an experience, not an explanation."

Therapist should be aware of whatever in himself blocks full presence; real confrontation between two people can be profoundly anxiety-creating; it is much more comfortable for the therapist to focus on the patient as an object and himself to be a manipulator of the object.

The aim of therapy is to have the patient experience his *experience as real*, fully become aware of his potentialities and become able to act on the basis of them. The neurotic's existence has become dark, clouded over, blurred -- therapy should illuminate his existence. The neurotic is overconcerned about the Umwelt, underconcerned about the Eigenwelt; the therapist must guard against the patient's taking over the Eigenwelt as his own emerges and seems to be weaker than the therapist This is quite different from helping the patient to "adjust" to the culture, which implies a further deadening of his existence.

Commitment: Truth exists only as the individual himself produces it in action. What is going on, that the patient has not found some point in his own existence to which he can commit himself unconditionally; everyone constantly faces the threat of nonbeing if he allows himself to recognize the fact; the therapist is doing the patient a disservice if he takes away from him the realization that it is entirely possible he may forfeit his existence, and that may well be precisely what he is doing at this very moment if he is denying his existence. "I know only two things --(1) that I will be dead some day,(2) that I am not dead now. The only question is what shall I do between those two points."

Refrain from evaluations of any kind; do not look for bizarre, absurd, illogical expressions; rather try to understand the particular world of experience of the patient -- how it is formed, how it falls apart; see it as a gestalt rather than a set of symptoms.

Try to transcend the split of Being into subject (man) and object (thing, environment) and replace it with the unity of existence and "world." (In psychoses, the freedom of letting "world" occur is replaced by the unfreedom of bing overwhelmed by a certain "world-design." There are as many worlds as there are psychotics.)

Being in the world: Common problem today for all -- isolation, alienation, moving about in a haze, no direct-sense-connection with own world -- adds up to lack of communication or interpersonal relations. Also man is alienated from the natural world -- he has been busy gaining power over nature -- now he is estranged from it. Also he is estranged from his own body. Person and his world are a unitary, structural whole -- self and world imply each other. This does not mean a spatial arrangement or his position in his environment -- there are other world modes.

World is the structure of meaningful relationships in which a person exists and in the design of which he participates; it includes past events which condition his existence as he relates to them, is aware of them, carries them with him, forming them in every minute of relating, plus all future possibilities beyond his "culture."

World Modes

Umwelt: all the natural world, objects about us, biological needs, instincts, natural laws and cycles -- all the world that would still exist if we had no self-awareness -- the world to which each must in some way adjust.

Mitwelt: world of interrelationships with human beings -- not adjustment or adaption -- this makes of the other an object. The essence of relationship is that in the encounter both persons are changed unless those involved are severely ill or have no degree of consciousness -- in which case there is no mutual awareness.

Eigenwelt: made of self-awareness, self-relatedness; the basis on which we see the real world in its true perspective and on which we relate to it -- what something in the world means to me. Without this the individual is aridly intellectual, loses vitality and the sense of reality of his experiences.

These three worlds are interrelated and condition each other. Man lives in all three simultaneously. The reality of being in the world is lost if one of these modes is emphasized to the exclusion of the other two.

Transcending the immediate situation: Man has this capacity; existing involves a continual emerging, a transcending of one's past and present in terms of the future. He can bring the distant past and the long-term future into his immediate present. This capacity is an inseparable part of self-awareness -- the basis of freedom of choice.

Anxiety, phobias, guilt: Anxiety must never be separated from "world"; it emerges when world becomes shaky or threatens to vanish; the emptier, more simplified, more constricted the world-design to which an existence is committed, the sooner will anxiety appear and the more severe it will be.

Phobia is always an attempt at safeguarding a restricted, impoverished "world"; anxiety expresses the loss of such a safeguard, the collapse of the world, and thus the delivery of the existence to nothingness.

Anxiety is the experience of the threat of imminent nonbeing, not something we have but something we ARE. It involves inner conflict between being and nonbeing; it occurs at the point where some emerging potentiality or possibility of fulfilling his existence faces the individual. This possibility destroys the present security; the present security then attempts to destroy the new emerging potentiality. Thus anxiety is connected with the problem of freedom -- it is the realization of freedom as a potentiality before this freedom has materialized.

When the individual denies these anxiety-producing potentialities, his condition is GUILT. The individual is GUILTY, NOT HAS GUILT. He is guilty when he denies or refuses to accept any aspect of himself (Eigenwelt), when he fails to perceive totally the other person, thus doing him a disservice (Mitwelt), or separates himself from nature as a whole (Unwelt).

Ontological guilt: Everyone participates in it; no one fully fulfills his own potentialities, sees his fellow men with no distortions. It does not come from cultural prohibitions, introjection or cultural mores -- it is rooted in self-awareness. It is not morbid or neurotic guilt -- this is avoidance of ontological guilt (same for anxiety). Once accepted, it is not morbid or neurotic. Ontological guilt does not lead to symptom formation but has constructive value -- it leads to humility, sharpened sensitivity in relationship to others, increased creativity in the use of one's own potentialities.

Contributions: Main contribution is the understanding of man as BEING. Man can be understood only in the context of the structure of his being or existence. Grasping of the being of the other person occurs on a quite different level from our knowledge of specific things about him. If we consider man as capable of being analyzed and reduced to original data we may end up with an imposing system of substances which we may call mechanisms or patterns but the MAN disappears -- we can no longer find the ONE to whom this or that experience has happened.

We subordinate existence to function -- what a man does. BEING is what remains AFTER we have extracted, analyzed, and understood all of a man's drives, instincts, and mechanisms.

BEING: someone in the process of being something, a source of potentiality by which a man becomes what he truly is. BECOMING is a better word.

HISTORY AND DEVELOPMENT
OF PSYCHOTHERAPY

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HISTORY AND DEVELOPMENT OF PSYCHOTHERAPY

Early Babylonians, Egyptians, and Greeks used magic, music and prayer for quieting patients and luring demons from their bodies. From about 1530 on, many doctors became aware of the value of kindness and humane treatment for mentally disturbed patients.

Mesmer (1734 - 1815) started by using magnetized iron, having a patient sit with back to north, used soothing music, made passes in front of patient's face, stared into his eyes; patient would fall into a trance during which he would be told that his symptoms would disappear. French scientists, testing Mesmer's theory, found that a patient could be helped by being deceived into believing he was in the vicinity of one of Mesmer's magnetized objects; also that no results were achieved if he was in the vicinity of it but didn't know it. They concluded that "imagination does everything - the magnetism nothing." Mesmer's method was discredited because of this fallacy and because of the exaggerated claims made by some of his followers. (By 1840 mesmerism was being used effectively for anesthetizing surgery patients and was often used until the discovery of anesthetics.)

Braid, an English physician used induced sleep, called it "hypnosis" and explained it in terms of fatigue of the sensory nerves.

Liebeault (French) founded a clinic, treated patients by hypnotizing them and telling them that their symptoms would disappear. (Modern method of "hypnotic suggestion" descended from this school.)

Charcot, a famous neurologist in the latter half of the 19th century, gave many demonstrations working with hypnotized hysterics, but his main interest was experimentation, not therapy.

Breuer (Vienna) discovered that one of his patients who had paralysis of 3 limbs, disturbances of sight and speech, inability to eat, nervous cough, dual personality, plus many more symptoms, would get temporary relief after talking to Breuer during a hypnoid state (caused by her dual personality.) One day she told him the details of the *first appearance* of one particular symptom, after which the symptom disappeared. He had her do this with her other symptoms, and since her hypnoid states were unreliable (in time and duration) he induced hypnoid states by hypnosis. He called the process *catharsis* - his patient called it the "talking cure."

Freud (1856 - 1939), was impressed by Breuer, but found hypnotism unsatisfactory as not everyone responded. Also patient sometimes could not recall what had happened during hypnosis. Another doctor suggested that Freud lay a hand on patient's forehead and tell him that the memory would return. This worked and also showed Freud how to dispense with hypnosis. He had patient concentrate upon remembering when the symptom first appeared; if patient had difficulty, recall was facilitated by Freud's placing his hand on patient's forehead. He called this technique "psychoanalysis."

The history of psychoanalysis for the next 30 years -- 1896-1926 -- is the intellectual biography of Freud.

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Primitive Psychoanalysis: *Aimed* at inducing the patient to recall traumatic incidents from early childhood, through the *techniques* of concentration and free association.

Theories:

1. *Traumatic incidents* were thought to be sexual seductions by an older child or an adult. At first Freud rejected the emphasis on sex expressed by other physicians, but his experiences with repressed Victorian women made him reluctantly come to similar conclusions.

2. *Repressions* - repressed material always carried some emotional distress.

3. *Resistance*- was the force which kept repressed material from appearing in consciousness.

4. *Abreaction* -- revival of a memory had NO therapeutic effect unless accompanied by the strong and distressing emotion that accompanied the original experience.

Later Freud began to suspect that some of the sexual "seductions" were fictional. However, they appeared so frequently and were accompanied by such real emotional distress, that he could not disregard them. He concluded that the memories were of fantasies. He studied the development of his own children and concluded that children did have sexual feelings - that psychoneurosis still had its origin in the sexual life of the child, but it could have been wishful thinking, not actuality. He enlarged his concept of the unconscious, stating that personality was the interaction between 2 psychic forces - pleasure-seeking libido (love) and aggression (hate). He changed his theory of psychoneurosis from being caused by a traumatic incident, to that of faulty development of the individual's unconscious.

His technique changed from inducing the patient to recall a sexual seduction, to releasing from repression the instincts which had been too severely repressed in infancy. He made no suggestions and dropped all techniques except free association, but soon found this very limiting.

He noted the prevalance of *dreams* appearing in free association and developed techniques of interpreting dreams which he said were attempts to fulfill in fantasy some repressed wish. From the dream material he made certain inferences about the content of the unconscious. However, the dream material is masked or distorted, so he started to use symbols and used this same technique with the waking thoughts of the patient. With interpretation, he could induce the patient to recognize, accept and make conscious, his present attitudes and emotions. (He used interpretation only as an adjunct when unable to get satisfactory results from free association.)

Transference: during analysis, released feelings of love, sexual attraction, dislike, etc. for a parent were transferred to the analyst. Freud would analyze the transference by showing the patient its childhood origin. (Because of the phenomenon of transference, Freud limited his contact with patients to his office.)

Later Theories: ambivalence, ego-id-superego structure, defense mechanisms (regression, sublimation, projection, isolation.)

FREUD'S MAJOR THEORIES:

1. There exists in man, in addition to the conscious part of his mind, an unconscious part of which he is unaware but which governs much of his behavior.

2. Man is driven by 2 main instincts: self-preservation (hate) and procreation (love).

3. From birth, man undergoes psychosexual development which matures in adult sexuality.

4. The main psychosexual crisis that everyone has to overcome is the Oedipal conflict - child becomes emotionally attached to the parent of the opposite sex and wishes the parent of the same sex out of the way.

5. All little boys fear castration because of their incestuous wishes. All little girls envy boys for possessing a penis.

6. There are two self-preserving psychic forces: repression which helps man escape those memories and desires he believes to threaten him, and resistance which blocks knowledge of repression and keeps him from admitting the dangerous truths that have been repressed.

7. The mind of man is divided into 3 parts - ego, superego and id.

8. Dreams are essential to his well-being, physically and psychically.

9. Traumatic childhood experiences and fantasies about them can later haunt an adult and cause severe distress.

10. Every child wishes to possess his parents' love completely - when parent shows love for a brother or sister, the child feels deprived of love - hates brother or sister and wishes him or her dead.

11. Civilization is the result of the sublimation of our aggressive and sexual drives into socially-approved channels.

12. Normal personality - conflicts between instinctual drives and morality standards have been comfortably resolved.

THE MIND: consists of the conscious, unconscious and preconscious. The unconscious lacks any sense of what we call reality - it cannot distinguish between a truth and fantasy. Therefore we live in 2 different kinds of reality - the actual one of our environment and our "psychic reality" composed of dreams (waking and sleeping) and fantasies. If these are very strong, we act as though they were true, even though they may be false. The unconscious stores memories of past experiences (real and imaginary) and their accompanying emotions.

The preconscious is an intermediary between the conscious and the unconscious - it holds thoughts that could easily slip into the conscious. It is a repository and a censor - protects from knowledge that might be too dangerous to admit to consciousness directly.

ID, EGO AND SUPEREGO: ID contains primitive impulses and passions - completely lawless - no moral sense - pleasure at any cost - no sense of time or order - full of contradictions - love and hate exist side by side - new-born infant is almost wholly id.

EGO - reason, sanity, control of the id - ego tries to make sense of the environment and of our experiences - tries to live by the reality principle instead of the pleasure principle - self-esteem, self-respect, pride all linked to the ego.

SUPEREGO - conscience - teachings of parents and society - if there is too much tension between ego and superego, we feel guilt.

All three parts direct our lives - the id and superego engage in fighting - the ego is the battleground between passionate id and strict conscience - if ego is strong, person can direct the impulses of the id so that life becomes rich and rewarding, rather than self-punishing. Primitive instincts can be used constructively and imaginatively. If superego is in charge and moral code too strict, guilt and unhappiness results - if id is in control, ego is weak, self-esteem is low - resulting in unhappiness also.

PLEASURE PRINCIPLE - infant starts life narcissistic - what brings him pleasure he loves - what brings him pain he hates - just wants to satisfy his needs. As he begins to grow up, he begins to want his parent's love - sometimes this is withheld if he follows the dictates of his id impulses - conflict ensues - he must learn to put off immediate gratification and try to adjust to the "reality principle."

FANTASY - interwoven with instinctive drives - part of one's imaginative creative spirit - attempt to explain mysteries in life in a way that is least harmful to self-respect.

INFANTILE SEXUALITY AND PSYCHOSEXUAL DEVELOPMENT

Freud's use of the word sexuality encompasses all that is involved in "sensuality."

Libido - energy that is in all feelings of love (people, objects, ideas) - if there are no love objects available to the child, libido may remain attached to himself - as an adult, he is unable to love another person.

Complex personality traits derive from forms of libido:

oral libido - insatiability, desire to exploit

anal libido - orderliness, hoarding, obstinacy, sadism

genital libido - capacity to love

Stages in psychosexual development - oral, anal, and genital. First 2 occur before the age of 5 - genital during adolescence. From 5 to adolescence is the latency period.

Oral - feeding, pleasurable sensations of the mouth, sucking, biting.

Anal - bowel control - Freud felt there is some erotic pleasure associated with excretion - also that this is the period when child first discovers he may have power over his parents.

Genital - sexual maturity.

Too much frustration at any one of the 3 psychosexual stages may lead to sexual conflicts.

DREAMS

In ancient times dreams were considered to be ancestors speaking, omens, angry or pleased gods, signs of good and bad luck, etc. There was writing about dreams as early at 1800 B.C.

Plato quoting Socrates: dreams reveal man's desires "which are awake when the reasoning and human ruling power is asleep; then the wild beast within us, --- goes forth to satisfy his desires ---. In all of us, even in good men, there is a lawless, wild-beast nature, which peers out in sleep."

Aristotle was the first to speak of dreams as part of man - not something outside him

Cicero - dreams have no order and "no one image has the same meaning for different people - it is not constant even for the same person."

Lucretius - dreams a product of the unconscious mind, a fulfillment of wishes, and they revealed guilt.

FREUD synthesized all previous valid ideas on dreams and added his own theories:

1. Dreams mirror wishes and fears, primarily secret wishes.

2. Most dreams reflect sexual wishes and fears.

3. We dream about the hidden instinctual desires which fulfillment we must unconsciously deny, or that which is forbidden.

4. No one image has the same meaning for any 2 people.

5. Dreams mirror intense emotions - thse we believe too frightening to admit to the conscious self - furies, hungers, guilt - and from them get gratification for all past emotional deprivations.

6. Dreams condense - use symbols. However, he felt that symbolism and dream interpretation were only a part of unraveling the material in dreams and could never replace free association as effective therapy - interpretation of symbols was of value only as a complement to free association.

7. During sleep the conscious relaxes - the preconscious takes over and allows some of the forbidden material to be remembered.

8. Dream fantasies are usually based on a fragment of the truth.

Individual Psychology and Counseling - Adler

Adler - (1870-1937) was not analyzed by Freud, but was affiliated with him in study groups and publishing a journal. He broke away when he began to disagree strongly with Freud and formed his own group which he called the "Society for Individual Psychology."

Main divergencies from Freud:

1. Freud was interested in the patient's experiencing repressed emotions - Adler in the patient's recognizing unpalatable facts about himself and seeing how his symptoms fitted in with these facts.

2. Freud was concerned with origins of neuroses - Adler was interested in "healthier" goals - showing patient errors in his present goals and helping him substitute social goals for his present defective ones.

3. Neurotic symptom - Freud saw this as a result of conflict between irreconcilable instincts. Adler saw it as a result of the ascendant instinct - claimed this enabled him to treat the individual as a whole person, which was his goal. Individual psychology meant "psychology of the indivisible personality."

Other Adlerian theories:

ORGAN INFERIORITY: When an individual has a weak organ, he tends to compensate by overdeveloping in another area - he also does this psychically. Everyone has a general sense of inferiority and will tend to find a way to compensate. If he does this through direct competition, it is not neurotic. If he distorts his compensation, (such as withdrawing from competition into illness) he is neurotic and develops a neurotic "life style." (Women suffered from inferiority complex more than men because of male dominance in society.)

COMMUNITY FEELING: Tenderness, friendship, love. (opposing force was domination or need for power stemming from inferiority feelings.)

TECHNIQUE: Chiefly interpretation in terms of patient's aggressive striving for superiority. He did not wait for patient to become aware of his behavior, feelings, thoughts, symptoms, etc. - as soon as Adler saw these clearly, he would tell the patient. He also tried to reeducate the patient and make him a more constructive member of society.

ANALYTICAL PSYCHOLOGY - Jung

Main divergences from Freud:

1. Freud searched for sexual features - insisted that infantile sexual development was at the root of all problems - Jung accepted sexual discussion but did not search for it and when it did arise, he looked for explanation for the libido's taking that particular form.

2. Jung strongly interested in mythology and dissociation. Freud felt that the unconscious consisted entirely of memories, fantasies, desires and emotions repressed during childhood. Jung accepted this but added "collective unconscious" (inherited memories, fears, etc.) and potentialities of character which the patient had been unable to realize.

Other Jungian theories: Child is born with certain constitutional dispositions (introversion, extroversion, sensations, logic,emotions, etc.) AND ways of thinking, feeling, and behaving which he inherits from remote forebears. Neurotic selects an archetype and then fails to fit it. Some features or eccentricities of the personality can be valuable and do not have to be "normalized" or analyzed out of existence. He agreed with Freud that therapy often consists in removing patient's repression and reconciling him to less savory aspects of his personality and added that the therapist can help the patient fully develop all his unconscious potentialities.

Techniques:

1. Re-education - no setting of goals by therapist.

2. Catharsis - when necessary - not in all cases.

3. Interpretation - Jung's main technique - he felt sure that the patient could not possibly arrive at insights referring to material in his "collective unconscious."

4. Dream-interpretation - very important - therapist should point out the dream's myth-like aspects plus its diagnostic or prognostic aspects.

5. Free association - used this less than Freud - he used word-association tests as a quicker means of getting a rough idea of what the patient was repressing - any abnormal response indicated a problem and the diagnosis was formed.

6. Transference - Freud felt that the therapist should remain completely impersonal and detached - Jung believed the therapist could be helpful by reacting naturally toward patient's attitudes - adding that every therapist should have a complete analysis so that his reactions would be "healthy" and thus help the patient understand his transference.

7. Picture-making - induced patient to draw or paint subjects of dreams and fantasies - by doing this, patient takes more responsibility in the act - fantasy becomes clearer.

Otto Rank: Rank objected to Freudian analysis, saying it aimed at changing the neurotic person into an ill-defined, formless, average person. He believed the neurotic had more in common with the creative person - both are strong-willed, except the creative man's will is affirmative, the neurotic man's will is negative. Because of conflicts, the neurotic is unable to live up to his aspirations and therefore he denies them - because of his denial of will, he suffers from guilt feelings. The individual needs faith in himself, his own truth, illusions, and developing his own ethical standards.

Rank recognized the positive, creative directional nature of man's striving. He spoke of "will" and rejected the idea of man being pulled and pushed by impersonal forces. The neurotic is at an impasse; he is bound by conflict of positive will and fear of the consequences of will. To will without guilt, to be oneself without fear, is the mark of health.

Therapy seeks to free the person from this conflict, to assist him to gain acceptance of himself in all his uniqueness and with all his ambivalences. Rank puts the patient directly at the center of the therapeutic process - the therapist is available as "ego-helper", working on those aspects of self felt by the patient to be disturbing; more concerned with present than past; less concerned with content of patient's life and more with his immediate experiences of living in relationship to therapist; avoids giving love as this would create dependency; makes no attempt to educate as this would intensify the neurotic conflict.

"Real psychotherapy is not concerned primarily with adaption to any kind of reality but with the adjustment of the patient to himself - the acceptance of his own individuality or of that part of his personality which he has formerly denied."

Rank's psychotherapy was the fore-runner of client-centered or non-directive therapy.

Birth trauma: Two factors - 1. a desire to return to the womb, expressed in a need for dependency; 2. a desire for rebirth, "will" to grow, to achieve self-actualization. Rankian analysis emphasizes the resolution of the conflict between these two contradictory strivings. The therapist concentrates on mobilizing constructive elements in the personality so that the patient can resolve his fears of separation and achieve growth and independence.

Non-directive or client-centered therapy:

Rogers (1902 -   ) Originally interested in personality testing, formulating diagnosis, and giving advice based on the results. He gradually shifted his interest to the patient-therapist relationship and psychoanalytic orientation but avoided its terminology.

Theory: Catharsis (Freud), insight (Adler), and natural drive for recovery. He considered insight the most important factor in therapy but stressed intellectual rather than emotional insight.

Technique: Inducing patient to talk as freely as possible about all aspects of his symptoms or difficulties - the therapist is merely a clarifier or mirror. Topics are chosen entirely by patient (not so with Freud or Adler.) Rogers made no effort to induce catharsis of childhood experiences, gave no interpretations, did not use free association.

Levy and Taft: Focus on the present rather than the past. Instead of having the patient retrace his developmental steps and relive emotional experiences, feelings and attitudes are handled in terms of the present therapeutical relationships, in the belief that positive growth can be achieved in this relationship itself. The emotional interaction between patient and therapist permits the free expression of strivings and feelings with complete acceptance and understanding, making an atmosphere in which the patient can realize his potentialities and, through insights gained in this relationship, he is able to re-adapt himself to life situations.

Snygg and Combs (phenomenological): Behavior is determined by the individual's own perceptual field. The therapist's task is to facilitate the patient's exploration of his own perceptions by communicating to the patient an emphatic understanding of the world as he, the patient, sees it. At the same time, the patient is provided with an opportunity to bring about changes in his perception of himself that lead to self-realization and self-enhancement.

Focus is on the individual - not the problem. No diagnosis is made. The therapist has a permissive, non-judging and accepting attitude in order to allow free expression of the patient's own feelings and attitudes. The therapist responds to the individual's emotional experience rather than the intellectual content of his verbalizations. No effort to guide him, provide information, give advice.

Hypothesis of client-centered or non-directive therapy: In each individual there are residual growth potentials which need only to be released to enable him to achieve maturity. Maladjustment is not due to lack of knowledge or failure in problem solving but rather to a blocking of knowledge by feelings and attitudes that are not understood by the patient. The main role of the therapist is to provide a unique situation of acceptance and recognition, to refrain from imposing his own patterns and values on the patient, so that self-understanding and growth may take place directly in the therapeutic relationship.

Techniques: Emphatic reflection of feelings, rephrasing of verbalizations, to help patient clarify facts for himself and recognize his own emotions without fear.

1. Attempt to understand what the client is saying with reference to content, feeling and import to the client, and to communicate this to him.

2. Condense or synthesize the expressed feelings of the client.

3. Accept what client has said, implying that it has been understood.

4. Define, when relevant from the client's point of view, the nature of the therapeutic relationship, expectancies of the situation, and limits of the therapist-client relationship.

5. Convey to the client a sense of acceptance and of confidence in his ability to handle his own problems.

6. Answer questions and give information when relevant to the treatment, but may refrain when it may implement dependency.

7. Actively participate in the session, keeping alert, trying to catch nuances of feelings, interrupting if necessary to make certain of understanding what the client is saying and feeling.

8. NONE of the following: interpreting client's behavior within the therapist's hypotheses or theories; trying to promote insight directly; advising, moralizing, praising, blaming, teaching, planning programs of activities; diagnosing; asking probing questions; suggesting areas for exploration.

Primary difference from other schools: Leaves more of the responsibility for the course and direction of therapy to the client - choice of topic, finding of meanings, moving ahead or resting while in the comfort of old defenses, and final resolutions.

Directions of change in therapy: Movement is from symptom to self, from environment to self, from others to self, and from past to present. Client learns that it is safe to leave his symptoms, others, environment, etc. and focus upon the discovery of "me, here and now."

Other values derived from therapy: Increased differentiation of the perceptual field. The individual abandons gross and often inaccurate abstractions regarding his life circumstances for more specific and accurate formulations - resulting in increased appropriateness of his behavior, more accurate appraisals offering a much sounder basis for judgment and expectations of others and more reliant on own experience.

Repression of responses: We do not come by our maladjustments, our neuroses or psychoses because of lack of understanding. We learn them through concrete experiences that are hurtful to us - they start early in life and involve us and our relationships with the few important persons in our early life. We understand all too well how it hurts not to be loved, to be denied comfort, deceived, doubted. It hurt when it first happened and it hurts so much now when recalled that we do not permit the recall. Instead we repress, evade, distort, and, in so doing, perpetuate our difficulties with people.

Insight into all this cannot help. The efforts to promote insight can only change behavior by encouraging repression of responses not approved by the therapist, since the client does not want to lose the support of the one person who seems to be on his side. The therapist can help - not by trying to promote understanding, but by making available to the client learning experiences that are as concrete, as immediate, as compelling, as the learning experience that initially started and then nourished his neurotic way of living. The act is more important than the idea - the personal symbol more important than the insight.

Directive and Eclectic Personality Counseling - Thorne.

The term "directive"is unsatisfactory, but it was determined by the conviction that damage could be done by the wholesale use of Rogerian non-directive therapy. Also there is direction in any therapeutic relationship - the therapist is experienced and trained and therefore dominates through prestige. The need for direction is inversely correlated with the patient's potentialities for effective self-regulation. The healthier the personality. the less need for direction - the sicker, the greater the need for direction. Effective therapy often involves a compromise between what a patient sincerely believes he wants and what he needs in the objective judgment of the experienced therapist.

Theoretically it is desirable to depend upon the growth principle, but there are many cases in which the client's resources and growth potentials are so deficient or damaged that adjustment without outside help and direction in impossible. The therapist should make direct interpretations of manifest behavior in the most direct and economical manner possible.

Goal: Establishing suitable conditions for learning to take place and providing suitable training situations according to the psychology of learning so that reconditioning actually takes place and is translated into action. Many psychoanalytic and non-directive techniques can be used in achieving this goal.

Diagnosis is of primary importance: After making a careful diagnosis the therapist must devise and institute suitable training procedures for the correction of the problem.

Thorne concentrates on marshaling patient's intellectual resources, training in self-regulation, reorienting attitudes. Therapy focuses on actual situations, past and present, which have led to current symptoms in the form of infantile reactions, erroneous attitudes, and unhealthy habits of thinking and acting. Techniques, ranging from support and reassurance to disclosure of factual information are used to re-educate patient in the development of more constructive and socially approved attitudes, and the practice of more rewarding behavior patterns.

Although Thorne recognizes the importance of tension release and the establishment of a positive emotional relationship between patient and therapist his chief tool of treatment is the intelligence of the patient, and the appeal is to his reason and self-respect.

COMPARISONS BETWEEN DIRECTIVE, NON-DIRECTIVE, AND ANALYTIC

Expressed feelings: Non-directive clarifies and reflects; analytical interprets feelings before they are expressed or when expressed in disguised forms; directive interprets, but in terms of intellectual content rather than in terms of feelings.

Applicability: Non-directive seems to be limited to those with relatively sound personality structures in which anxiety does not block emergence of positive growth potentials - a patient with serious emotional problems may avoid his anxiety and even choose to retain neurotic defenses.

Directive: when objective is to help withstand anxieties and stresses of everyday life and to use his abilities more effectively; with dependent personalities who are unable to take any decisive action without authoritarian directives; with individual who is endangering himself or others through uncontrolled emotionality; immature individuals who tend to "act out"; those who are sufficiently flexible to alter behavior patterns when their distorted attitudes are brought to their attention and clarified.

Analytic: concerned with investigating and resolving conflicts that underlie distorted attitudes and neurotic behavior patterns and with reorganization of the character structure. Especially applicable to those with whom a transference relationship can be established since this is the main tool - conversion hysterics, anxiety neuroses, some compulsive neuroses and neurotic depressions. Not effective with psychopaths who will not and schizoid personalities who cannot, withstand the symptomatic suffering of the uncovering process and the transference.

Group therapy can be used with any of the above approaches - value is that the multiple relationships with others affords opportunities for expression of feelings, for gaining a sharpened awareness of neurotic patterns, and for constant reality testing for interactions with manifestations of hostility, fear, and abnormal behavior of other members. More effective with patients who have some understanding of themselves and thus are able to see their neurotic patterns in a group setting and make connections between the expression of emotion and its relationship to basic character structure.

Hypnosis: not for non-directive because it involves a relationship in which the therapist imposes his will on the patient; directive - may be used to remove symptoms thru direct suggestions and to obtain abreaction of suppressed feelings; analytic - may stimulate recall of traumatic memories and facilitate the production of associations and related emotions; aid in development and use of the transference relationship when serious resistances are met. However, the repressed material uncovered during hypnosis must also be dealt with in the waking state so that it can become fully integrated with the ego.

POST-FREUDIAN PSYCHOANALYSIS

Object-relations school: (Abraham, Melanie Klein)

Theory: The neurotic behaves as if he had introjected or incorporated objects which had failed to satisfy him in early infancy - the oral period. Emphasis is placed on aggression and the "death-instinct."

Techniques: Search for material during very earliest life of the patient; interpret the very deepest buried impulses and attitudes, without preparing patient for the interpretation.

Cultural school: - 1930's - developed mainly in America although some of the founders were transplanted Europeans such as Horney and Fromm. Sullivan (American) was very influential.

Theory:

1. Interpersonal relations - problems seen as stemming from how the individual relates to others. Horney divided people into three groups - those who move towards others, those who move against others, those who move away from others.

2. Aggression - Fromm who was greatly interested in sociology and anthropology believed that aggression was the product of our society where the caste system had broken down; technology encouraged ambition, but very complex system of laws and conventions made the fulfillment of these ambitions very difficult to achieve - result frustration, leading to aggression.

3. Self-concept - neurotic builds up an unrealistic picture of himself and others - therapy must correct these concepts.

Techniques:

1. Induce patient to talk about behavior and feelings toward the people with whom he comes in contact; to talk about how he sees himself and others.

2. Less emphasis on going back to childhood except to determine when patient began to use undesirable attitudes towards people.

3. Interpretation and dream-interpretation - very important - used to clarify patient's uncounscious attitudes towards people.

Sullivan: Anxiety has a central place in the formation of personality.

Personality is basically formed through interaction with the significant people of early childhood.

Human Needs: 1. Satisfaction of biologic needs and acquired needs.

2. Security - interpersonal need based on the desire for acceptance and approval. This need for security determines the personality development; chief factor in personality's functioning is the attempts to avoid anxiety.

Child's first interpersonal relationship is with the mother - very close, physical - from this he gets pleasure - "euphoria" - if mother is anxious, child experiences unpleasure or loss of euphoria. Later this unpleasure becomes anxiety. He learns that certain behavior is acceptable and certain other behavior is not - tends to mold his life in such a way as to produce the minimum of anxiety. Tends to dissociate completely from the most disturbing aspects of himself - they become the "not me" - the acceptable aspects become the "me". Some of the unacceptable traits are not successfully put out of awareness and are labeled "bad." Acceptable and conscious unacceptable traits become the child's idea of himself - his bulwark against society - he must keep this "idea of himself" unchanged. Any attempts to bring aspects of the "not me" into awareness and include them into the "idea of himself" are anxiety-producing and must be avoided. The more intense the early anxiety experiences, the more rigid the self system.

Fromm disagreed with following theory of Freud: society is a police force created to control man's instincts of sex and destructiveness: therefore, the more civilized the individual becomes, the more frustrated he becomes.

Fromm says that man is the least instinct-ridden of all animals - has fewer ways of reacting at birth than any other creature - he must be taught how to live. Therefore, most of his drives are created by his society, such as lust for power or craving for submission.

Western evolution made man more an individual, with new problems - can no longer rely on static forms of behavior - must learn to think. He becomes aware of his powerlessness in the universe, becomes aware that he must die - feels more alone. Conversely, he has become freer, able to develop his powers more and more, attain greater mastery over nature. His own creations, such as machines, have separated him more and more from nature - loneliness and feeling of alienation result - therefore he strives to return to some form of relatedness to his fellows, even at the cost of giving up some of his individuality - hence authoritarianism, relationships of hate, suffering, exploitation - none of these can be called love but they do save the individual from loneliness.

Personality types:

1. Receptive: developed in a home where parents wish to give and child knows he will receive.

2. Exploitative: developed in a home were things are not freely given, but can be got by taking or manipulating.

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3. Hoarding: developed in a home where there is a poverty of emotion - child learns to hang on to what he has, because there may not be anything more.

4. Marketing: product of capitalistic culture - one whose value of himself is entirely determined by the value placed upon him by others - tries to make himself into whatever the immediate people desire - cultivates traits which increase his sales value and tends to deny aspects of himself which are not saleable.

Authority: 1. rational: genuine, based on competence

2. irrational: based on need for power

First is aimed at freeing the subject, second at keeping him subservient.

Selfishness and self-love: narcissism is a defense against self-hate - based on low self-esteem and always a product of neurotic difficulty.

Sullivan claims that personality is developed thru interaction with others and he does not admit the existence of a unique individual self - says its a delusion. Fromm disagrees - says such a man is self-alienated - that his adjustment and cooperation take the place of genuine relatedness.

Fromm is much more concerned with maturity, capacity for love and productive work, ability to transcend one's culture.

Both say that instinctual drives are relatively weak in the human and not the usual cause of neurotic difficulty.

Horney

Personality - largely determined by the kind of relationships developed with other people - neurotic development results from disturbed human relationships.

Individual has within him a constantly-operating, positive, creative element which works toward genuine, healthy growth.

The neurotic lives with a delicately balanced compromise of compulsive and incompatible elements - when compromise becomes upset or he can't find one, symptoms appear - tension, anxiety, panic - "everything goes to pieces." His world is going to pieces, but he doesn't realize that it isn't worth saving.

AIMS: greater awareness of the present - linking past with the present - patient becomes aware of how and why the past patterns are operating in the present - this leads to genuine insight. He sees that his attitudes, feelings, etc. toward himself and others are incompatible, detrimental to his well-being, and no longer essential. VERY IMPORTANT GOAL - uncover strength presently being used neurotically.

Theory of development of neurotic personality:

Infant - reacts ONLY to physical comfort or discomfort. His needs are personal warmth, reliability, respect for his immaturity.

Child - same needs as above plus justice. If child or infant gets these, he feels loved - therefore SAFE.

Unfavorable psychic conditions: unreliability, inconsistency, overindulgence, oversolicitude, favortism, injustice, unrealistic demands, antagonism, humiliation, cruelty, parents who cannot love without ulterior or false motives. Any of these give child feeling of insecurity - he feels UNSAFE. (Inattention, coldness, remoteness can also give child feeling of unreality.) He feels helpless, abandoned - becomes hostile; his helplessness, isolation, hostility result in basic anxiety which also contributes to his feeling of being unsafe.

To allay ANXIETY he chooses one of the following neurotic trends:

1. move toward people - submissive, obedient
2. move against people - rebellious
3. move away from people - withdrawn

All these trends are present but he chooses one, pushes others into background. All are unsatisfactory and increase strength of the neurosis - (example: submissive child is taken advantage of.)

Primary defenses: He develops several of the following defenses:

1. stresses one set of trends - pushes others underground
2. externalizes his internal problems - blames others or circumstances; focuses on other people's difficulties or weaknesses.
3. constructs an idealized image of himself
4. detaches himself partially or totally from emotional relationships with others.

Secondary defenses: to support primary defenses, develops -

1. Blind spots - doesn't see contradictions or discrepancies.
2. Rationalization - to explain away inconsistencies.
3. Compartmentalization - behaves one way in public, another in private, etc.
4. Flippancy, cynicism.
5. Claims everything he does and feels in right
6. Elusiveness - becomes devious

Consequences:

1. Uses enormous amount of energy in maintaining defenses.- less energy left for developing healthy capacities, relationships, enjoyment of life; feels tired, futile.

2. Spontaneity, initiative, sustained action difficult; inertia, indecision.

3. False justifications and pretenses - blunted moral values; truth and honesty missing.

4. High egocentricity (even in the self-sacrificing) with resultant arrogance.

5. Hopelessness - caught in conflicts that cannot be resolved; feels doomed to frustration; becomes shadowy and unreal; no notion of what he wants.

6. Despair, resignation and hopelessness may lead to bitterness and rage against fate and others; may become sadistic or destructive.

7. Fears - some sharp, some diffuse; fears exposure, humiliation. Specific fears may become externalized and symbolized.

8. Depression - helpless feeling from conflicts leads to impotent rage; if rage is repressed, depression is diffuse - leads to self-pity; if rage is more conscious, he thinks of suicide.

9. Inability to think, concentrate, make decisions, etc.

10. Disturbed relationships with others - inability to get along, feels excluded. intense shyness or aggressiveness, inability to love or hate, sexual disturbances.

11. Physical manifestations - flushing or pallor, sweating, high or low blood pressure, muscular tensions, gastrointestinal upsets, migraine, etc.

12. Comforting or narcotizing agent (drugs, liquor) originally intended to allay anxiety, becomes habitual, uncontrollable, harmful.

The "successful" neurotic makes what appears to be a good adjustment to life, but there are deficits in character, achievement and relationships - he does not realize much of his potential.

Horney is optimistic in her rejection of instinct theories with their implied fatalism - basic premise: we are not passive agents victimized by unchangeable instinctual conflicts, but rather individuals WITH our culture carrying the responsibility for initiating, aggravating and perpetuating our own disruptive inner conflicts and, at the same time, carrying the capacity to change.

On this premise, authority toward the child stems from love and respect and not from fear and the need to repress and sublimate something considered to be instinctively anti-social.

Therapy should:

1. Be more concerned with the present self-perpetuating elements than with the past.

2. Bring to the patient's awareness a.) his protections against and his denials of his basic conflicts and b.) their intricate and complex interplay, such as self-hatred and moving away from self.

3. With the reactive and vicarious living of the patient, so driven to relieve or avoid anxiety that he has no feeling of his real self.

Unable to develop his own goals and profoundly weakened by basic conflicts, patient builds up an idealized image of himself because he cannot tolerate himself as he actually is. This idealized image becomes an inner tyrannical dictator.

Hypnotherapy

Return of Hypnosis: Starting around 1940 in the U. S., there was a renewed interest in hypnotherapy. It is considered not of permanent psychotherapeutic influence by itself, but effective as a catalyst and, when used, should be in conjunction with specific techniques.

Values:

1. Produces a remarkable relationship in which the hypnotist can make suggestions that are acceptable to the subject which enable him to experience widespread psychic and somatic effects. This is probably based on the fact that the trance symbolically represents a relationship with an idealized parental figure to whom the subject submits and whose suggestions he follows in the hope of winning love, support, etc. It expedites certain authoritarian therapies (reassurance, guidance, persuasion, symptom removal through prestige suggestion.)

2. Tends to modify or to remove repressions that keep certain aspects of the personality from awareness.

Symptom removal through hypnotic suggestion: Rapid and sometimes miraculous. Disadvantages - few persons are susceptible to this approach; effect may vanish and symptom may return in same or altered form; it deals with results rather than causes of an emotional problem. Problems that yield best are those having a minimum defensive or secondary value for patient - hysterical symptoms such as tics, spasms, etc. Habit disorders also may be helped (smoking, nail-biting, insomnia, etc.) Even though symptom removal deals with result and not cause, sometimes the result of some symptoms is so detrimental that subject's life and mobility may be extremely limited and perhaps even threatened; this is the principal value of hypnotic suggestion.

Hypnosis in supportive psychotherapy:

Aim: To bring subject to some sort of emotional equilibrium by overcoming his emotional decompensation as evidenced in anxiety or depression, by remedying his defenses against anxiety, by getting him to adjust to this liabilities, by expanding his assets to the fullest, by overcoming remedial elements in his environment, by helping him adjust to irremediable elements, by executing to the full his existing creative capacities.

Hypnosis can be used in conjunction with guidance, reassurance, persuasion, desensitization, and re-education. Where psychological analysis is impractical or impossible, persuasive therapy provides him with a mental crutch. The substitution of persuasive philosophical precepts for destructive habits is probably the lesser of two evils. Some obsessive-compulsives do very well with persuasion, sometimes better with analysis. In persuasion guidance and reassurance, an effort should always be made to bring about a change in the relationship from directiveness to non-directiveness, and to work with the dynamic roots of the patient's problems in an analytic way whenever possible so that he may obtain insight into his difficulties and a better understanding of himself.

Hypnoanalysis: Most important determinants of behavior are unconscious. Aim is to bring awareness repressed elements of the personality, to show the individual how his impulses and drives create symptoms, to show him the functions of his drives, and to explore their purpose and genetic origins.

Goal: Drastic re-organization of the personality structure, liberation of the self from conscience standards that contain introjected early disciplines, bringing the ego to a mature level of integration at which it can express basic biologic and social needs in conformity with the group. Unfortunately, the individual always seeks to maintain his status quo, to resist change.

Hypnosis exerts a striking influence on the resolution of resistance. Sometimes a trance is enough. Usually, however, special techniques are needed - free association, dream induction, automatic writing, hypnotic drawing, play therapy, dramatic acting-out, regression and revivification, mirror-gazing, and the induction of experimental conflicts. Most important are dream induction, free association, regression and revivification.

Hypnoanalysis may be employed in

1. Development of a transference neurosis
2. Producing desensitization (in which patient is helped to become aware of and to adjust to repressed elements in his personality)
3. Re-education through analytic insight

In 2. and 3. neurotic transference is avoided as much as possible.

Desensitization in hypnoanalysis: The objective is to help the patient become aware of memories and conflicts, and to deal constructively with the associated emotions. It is especially useful in hysterical conditions and traumatic neuroses.

Mere recall changes NOTHING in the basic character structure - the only thing that changes is that he is liberated from some of the effects (symptoms) of repression, and the influences of his conflict and its associated emotions. Through interpretation the therapist confronts the patient's conscious ego with the implications of his repression. At first the ego may be unable to accept the repressed material - he may deny its validity. However, as the conflicts or memories are brought up in increasingly-undisguised forms, the ego becomes inured to their influence and the patient becomes more capable of accepting them as part of himself. Since the material is intensely traumatic, the patient is urged to remember only these aspects of it that he can tolerate.

Results: Recall of the event and especially the accompanying catharsis of the associated emotion usually make the symptoms no longer necessary. However, there does not seem to be any permanent influence. The patient is not motivated to pursue further exploration into his present interpersonal patterns, unless the therapist can convince him of the value of further work.

Re-education in hypnoanalysis: The therapist attempts to bring the patient to an understanding of the dynamic sources of his difficulty, the meaning of his symptoms being demonstrated to him in terms of repressed conflict. Thus he is brought to an awareness of his conflicts, their influence on his present adjustment, their origin, and finally the ways in which his prevailing attitudes and patterns of behavior may be modified toward a more realistic and productive adaption. The medium is the relationship with the therapist, keeping transference at a minimum. Insight is achieved by an appeal to the intelligent, constructive forces of his personality. The therapist must be accepted as a benevolent authority, hostility and other irrational emotions must be kept as realistic as possible.

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GROUP PSYCHOTHERAPY

Group work was used by many schools including Mesmer and Coue. In 1905 a Boston doctor started personal hygiene classes for his tuberculosis patients at a clinic - found them to be not only educational but effective in raising morale and contributing to recovery. He and others extended this method to other chronic disorders and the educational classes developed into therapeutic sessions. Some of these began with relaxation exercises and were called "thought-control" clinics.

Didactic groups: During the first World War Lazell in Washington found that psychotic patients, inaccessible to individual treatment, improved greatly in groups where simplified lectures were given. Dr. Marsh in New York did the same, widening the variety of topics and having the patient engage in group activities such as community singing, committees, etc. Klapman, mostly with psychotics in hospitals, lectured on mental illness, case-histories, and wide range of other subjects. Also he had patients write autobiographies.

Adler's Groups: Started with child guidance clinics in 1921 where he interviewed the child and its parents in the presence of other parents, children, and teachers. He felt that this procedure would suggest to the child that his trouble was not a private affair and that others were interested in him.

Therapeutic Communities: Bierer (Adlerian) in England, combined psychotherapy with communal activities for the entire day - patients were encouraged to work out rules amongst themselves.

Interview Groups: (or "group analytic therapy") - main technique of modern group psychotherapy. Developed rapidly during 2nd World War. Regular meetings of the same group of patients under the guidance of the same therapist. Patients are encouraged to talk to each other about their symptoms, personal difficulties, and emotional conflicts. They are also encouraged to help interpret the feelings of other members. Patients learn to understand and accept emotional reactions of others and themselves, learn that others may have similar problems, etc. Usually patients have some individual therapy first. Some therapists group patients according to illness, type of problem, sex, age, and other classifications.

Non-directive Groups: Group consists of about 6 clients, rough age groupings, separate groups for psychotics, occasional special interest groups. They meet twice weekly for about 1 hour, membership does not change, each member is interviewed first, and most groups meet for 15 to 30 sessions.

The therapist must be the kind of person who is thoroughly accepting, sensitive to the feelings of others, able to communicate his understanding to them, free from urges to direct the group because of his needs , and have confidence that the group and its individuals can find their own best direction.

He tries to bring into action the therapeutic influence of the group itself. At first he must do almost all of the therapy, but be ready to let others take over, contributing when important feelings are not picked up or when conflict among members threatens. An effective group therapist is one who can maintain a minimum level of anxiety while encouraging members to take over. Most important factor is that members feel free from threat and be able to examine themselves openly in a safe atmosphere.

Progression and change: Findings: An increase in permissive and accepting behavior, a decrease in critical, evaluative, and interpretive behavior. At the beginning, each member seems to be almost totally involved with his own problems. Gradually he becomes less anxious, more aware of, then interested in, then helpful with, others. Expressions of insight, of positive planning, of positive attitudes, toward the self and others showed marked increase.

Psychodrama: Moreno in Vienna, after the first World War, started the "Theatre of Spontaneity". Instead of professional actors, he called for volunteers from an audience to enact scenes from their own "private worlds." His original purpose was to free the theatre from its traditional formalism, but he began to see that this activity gave the individual an opportunity to portray his personal problems, conflicts, etc. and achieve a catharsis. He came to the U.S. in 1927 and, in 1936 founded a sanitarium where he developed his techniques. Trained assistants play other parts in the psychodrama, other patients form the audience and are encouraged to discuss or participate in what goes on.

Moreno's orientation is existential - analysis of existence, new evaluation of the encounter, emphasis on the moment of action.

Spontaneity - creativity is the primary problem of psychotherapy. It is the central place in the formation of the self. Insight is NOT the major goal, but rather the ability to become spontaneous - learning through experiencing. Emphasis is placed on aiding the individual to develop a realization of himself, of all his facades, in a setting where he feels safer from judgments than he does in his outside environment.

Encounter (Begegnung) - the sum total of interaction - of great importance in helping individual free himself.

Anxiety - traumas accentuate or intensify, but do NOT produce anxiety - the origin of anxiety is the separation of the individual from the rest of the universe - he feels cut off, helpless, threatened by death - Begegnung tries to restore individual's union with the universe.

ACTION is vital to biologic life, mental life, and interpersonal relationships; instincts demand expression, excitement needs discharge.

There is no "oral," "anal," etc., zone - instead there is a zone which consists of various parts of the individual and his environment which meet and form a gestalt.

Group psychotherapy - means exactly that - therapy of the group rather than the individual, although actually individuals often do get solo therapy within a group. Interaction with others in the group is of the greatest value although lectures, interviews, analysis, interpretation are also useful.

Group should be composed of cross-section in miniature of the community in which the group lives and should function as a miniature society or universe within which all members are accepted and find opportunities for expression.

Patient-physician relationship is no longer the cornerstone of therapy - the crucial participants are the patients in the group; the therapist is only a member of the group with a special and important function within it.

Psychodrama - group psychotherapy with its conversation, interviews, analysis, insight, etc. is not enough - therefore psychodrama is used as a vehicle for the acting out of problems in a setting removed from reality, and where participants feel safe. It is a therapeutic acting-out in a controlled environment as a prevention measure against irrational acting-out in life. It aids the individual to actualize that part of his past life which he needs to re-experience - to most situations which he has never fully faced.

Psychodrama is based primarily upon concepts derived from analytic approach. Primary contribution - role playing, in which the patient spontaneously acts out his problems in dramatic form with other actors and with the therapist as director. Patient is stimulated to give full expression to his feelings and attitudes and thus achieve catharsis and desensitization. The resolution of deeper problems and conflicts is further advanced in his relationship to the other actors and the director. Used within the context of a directive approach - especially effective with patients who have a good deal of generalized inhibition.

Agents - chief therapist, professional auxiliary therapists and patient-therapists.

Method - patient is encouraged to choose a situation which he will act out - if he has difficulty, chief therapist suggests a problem in patient's home or job situation. Patient assigns auxiliaries to various roles and gives them information on roles they are to play - if possible, he enacts as thoroughly as possible these roles in order to give auxiliaries full understanding of them. He is asked to duplicate with as much detail as he can, the situation he has chosen to portray.

TECHNIQUES:

1. Cluster warm-up - group naturally tends to break up into clusters, each cluster talking about something - they may group and regroup - out of this, someone makes a strong statement pertaining to his personal response or involvement in what his cluster is discussing - he becomes the "star".

2. Specific problem is suggested by therapist, assistant or member of the group, roles are assigned. This is called the directive warm-up.

3. Spontaneous improvisation - patient acts in fictitious roles.

4. Role-reversal.

5. The double - auxiliary plays the same role portrayed by the "star" - sometimes he can verbalize or act out what he believes the "star" is feeling or thinking, but is too frozen to express.

6. Soliloquy - patient and auxiliary are assigned fictitious roles - they are encouraged to interrupt their role-playing with interactions between their real selves.

7. The mirror - auxiliary mirrors "star".

8. Dream enactment.

9. Interpretation - can be made by therapist, auxiliary, or members of the group.

Play Groups - Slavson in 1934, working with problem children in New York had groups of children play freely together under the charge of a therapist who interfered minimally. Claimed this had diagnostic and therapeutic value. Children too frightened or aggressive to derive value from the "play groups" were placed in groups where the therapist exercised more control over the activities and encouraged the children to express their violent feelings in talking rather than action - called "activity-interview: groups.

Therapist is not a leader, but the center of emotional cathexis. Members follow their own lines of interest. There is no common plan - each patient achieves catharsis and insight thru his own effort and by means peculiar to himself. Group is fluid, has little organization, seems to have no aim, direction or purpose, but all members have the purpose of correcting psychological distortions within himself and seeking his own improvement as a separate entity - there is no group aim.

Dynamics: interstimulation, interaction, induction, neutralization, identification, rivalry and projection. There is little cohesiveness - patients remain self-absorbed and preoccupied with their own problems. Group cohesion occurs seldom and when it does, it is temporary.

Therapist must be continually aware of the state and needs of each member of the group.

Suitability of patients for group therapy:

Patients who are inaccessible to treatment because of organic or constitutional defects, severity of problem, extreme regression, or excessive resistance may have to be excluded from groups.

Not all patients can be treated together - not all patients can respond to group - some patients may be traumatized if exposed to such direct interaction with others. No one type of therapy is effective with all patients.

Suitable for group treatment: Adolescent girls, even with serious emotional problems (if they can accept and participate in groups), patients who have anxiety and symptom neuroses, especially conversion, those with weak ego development, those with infantile personalities, confused (sexual) identification, ideological confusion without intense disturbances.

Non-suitability of patients for group therapy: Psychopathy, narcissism, obsessional and compulsive states, hallucinations, character neuroses, Idealogical confusion with intense distrubances, strong and uncontrollable need to act out in behavior or speech, calls for individual psychotherapy before group work.

Group composition: One unsuitable patient can block the group's work, avoid density of pathology and aggression. Too many intensely disturbed patients can re-enforce one another and create unmanageable tensions. Some patients should be neutralizers - those who dilute emotional tensions and show self-control; rage, anger, distress, self-pity are infectious - too much can prove too disturbing for the group; there should be enough variety of personalities and problems so as to avoid too great re-enforcement and over-intensification. Patients should catalyze one another.

Dynamics factors in analytic group therapy: Relationship, catharsis, insight, ego-strengthening, reality testing and sublimation. Often the release of inhibited or repressed hostile impulses will effect some sort of improvement.

When the patient, at the first interview, shows considerable anxiety, investigatory work is counter-indicated. The intensity will have to be diminished before the patient will be able to look at himself at even a short distance, let alone permit himself to feel and observe himself. Sometimes a few leading questions will allay the anxiety. Some patients, however, will interpret neutral questions as meaning the therapist is disinterested. If the therapist lets the patient go from one point to another, anxiety may be increased - this patient is looking for someone to take control. Sometimes systematic and chronological questioning will lessen his anxiety.

The ultimate aim of ideal treatment is to remove the defenses that have become pathogenic, leaving as little scar as possible. However, often a defense needs to be increased or strengthened and the symptom can be modified so that it no longer bothers the patient.

Helpful therapy entails a recognition of the relative strength and weakness of various drives and defenses. The therapist should be able to gauge when the patient can or cannot tolerate the investigation of his hostile impulses, when a hysterical patient may tolerate ventialation of his anxiety, when a schizophrenic may need reassurance and strengthening before his anxiety can be touched.

SUGGESTION AND CONDITIONING

About 1860 Liebault founded a clinic where he conducted experiements in hypnotic suggestion. Coue, a chemist shop owner, noted that certain drugs had beneficial effects, even though there was no physiological justification - he became convinced of the power of "imagination." He studied the techniques of hypnotic therapy under Liebault, made his own modifications, and in 1910, opened his own free clinic. He did not use hypnotic suggestion but did resort to tricks which would convince the patient that Coue had unusual powers. His beneficial results, like those of hypnotic suggestion, tended to wear off with time so he devised auto-suggestion which increased the effectiveness of the results.

Pavlov and behaviorism had tremendous effects on Soviet psychotherapy which includes:

1. Direct appeal to rational consciousness by means of logic, persuasion, scientific enlightenment, group pressures, and positive incentives.

2. Re-inforcement of positive influences through suggestion and, occasionally, hypnosis.

3. Removal of patient from harmful influences - involving him in wholesome experiences and activities, especially work activities.

PRESENT-DAY PSYCHOANALYTIC THERAPY:

Assumptions: Neurosis develops from the repression of vital experiences with important parental agencies, experiences centered around oral, anal, and Oedipal stages. Such repression is promoted by fear of the loss of love, or fear of punishment from parents, which has been internalized in the superego. Current thought is centered more on the meaning of these experiences to the patient, on the relationships to present events and to the defense mechanisms of the character structure, than on the mere discovery of sexual trauma.

Therapy: Focuses on bringing to conscious awareness derivatives of the repressed experiences and, through relationship with the therapist, the ego of the patient is strengthened to the point where he can withstand the anxiety associated with this repressed material. Primary diagnostic materials are free association and dreams. In the process of therapy, the patient must recognize and understand the repressed material as derivatives, in an attenuated from, of early fears and conflicts. To accomplish this, the therapist deals with the resistance and defenses of the adult character structure.

The most important technique is the transference relationship - the patient relates to a new parent figure (the therapist) and "acts out" his neurotic feelings and attitudes derived from experiences during his developmental period.

By means of strategically timed interpretations, the therapist exposes the nature of the transference as well as the defenses that the patient has used to perpetuate his neurosis. He helps the patient make connections between past and current events and to work through his problems by seeing how they condition every aspect of his life.

Usual term: 4 or 5 sessions weekly, 2 to 5 years.

Briefer psychoanalytic therapy: The therapist takes a more active role, may also use hypnosis and group therapy. Greater emphasis is placed on diagnosis so the therapist can focus interviews on significant material and manipulate the transference relationship by assuming roles in accordance with the patient's needs. The therapist may use various means to bring unconscious conflicts to awareness, deal with resistances, and control certain aspects of the transference relationship.

GENERAL REMARKS

There are two broad types of psychotherapy - supportive (direct assistance through persuasion, suggestion, relaxation, reassurance, etc.) and reconstructive (attempt to re-organize permanently the patient's personality structure.)

Goals of the various schools vary widely from relieving symptoms to improving interpersonal relationships, from increasing self-confidence and reality-facing to adjustment to the demands of society; increasing self-awareness, freedom of self, maximum development of potentialities.

No single approach is pertinent to all individuals. Strict adherence to one school causes grave errors - client at first may need ventilation, reassurance, and other supportive measures before he begins to feel the need for more intensive probing of his personality structure. With his changing needs and change in orientation to his problem, the techniques used by the therapist also need to be changed if patient is to derive maximum benefit from the therapy.

THE NEUROTIC

All schools agree that the neurotic is a person whose inner balance is disturbed, but they disagree as to dynamics:

Freud - difficulties of sexual development must be resolved

Adler - egocentric inferiority-superiority drive must be overcome by adjusting to society

Rank - uniqueness and independence of the individual must be established through creativeness and assertion of his own will

Jung - inner structure of the soul must be harmonized

Sullivan and Horney - relationship difficulties with others must be resolved

RECENT DEVELOPMENTS
IN THE
FIELD OF PSYCHOLOGY

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RECENT DEVELOPMENTS IN THE FIELD OF PSYCHOLOGY

The first two forces in psychology were behaviorism and psychoanalysis, in that order. The psychologists who advocated behaviorist theory were increasingly active during the last century and their main concern was with studying "man" as though he were made up of many parts. They focused on studying each part -- his actions, reactions, personality traits, patterns of behavior, learning, adaptation, and many other fragments of a "man."

One of their primary hypotheses was that a man was similar in many, many respects to various animals and, in order to find out how a human being functions, much study was done with rats, pigeons, dogs, etc. The assumption was that if an animal behaves in a certain way under certain circumstances, a man will do the same, or something like the same.

Along with this fragmentation of man for the purpose of study, the Industrial Revolution was occurring, which resulted in the loss of individuality for the individual -- he became a cog in a machine, a part of a nameless and dehumanized mass of other beings, and he was treated in this fashion by the psychologists and the governmental powers.

Some very great thinkers became alarmed about what was happening in these very strong forces which were dehumanizing man. Among these thinkers were several clergymen who began to make their alarms known, although few people listened to them. These men were the forerunners of what is now known as "Humanistic Psychology."

The next psychological force which appeared was psychoanalysis, a vast and complicated body of theory formulated by Sigmund Freud. There were many facets in his theories -- one of the most influential being that a person is primarily the product of his early years. He is shaped and molded by the important people (usually his parents, principally his mother) in the first few years of his life. From that point on, he will respond to other people in the same way he reacted to his parents and, in most cases, it will be very difficult or perhaps impossible for him to change unless he undergoes intensive and prolonged therapy.

During the latter part of the last century and the beginning of this one, a few voices were heard disagreeing with the theories of Behaviorism and Psychoanalysis. However, these voices were few and unheeded. Not until the last 20 or 30 years has there been any appreciable increase in the numbers and strength of those who believed that man is more than his separate parts, his reactions, and his early formative years. This group of people is now many and they constitute what is called the Third Force in psychology. They see an individual as greater than the sum of his parts, than his reactions, and potentially greater than what appear to be his limits.

In 1961, these people came together and formed the American Association for Humanistic Psychology. The movement gathered momentum, psychologists, social scientists, and others in other parts of the world became interested and enthusiastic, and now the association is international.

This association is committed to the fundamental uniqueness and importance of human life. Its aim is to study such areas as love, creativity, growth, warmth, play, self-discovery, self-responsibility, meaning, courage, self-actualization, spontaneity, and peak experiences.

Many brilliant Americans have been exploring some of the above areas. One of the outstanding contributors was Abraham Maslow who has done much valuable work in the field. One of the questions that he posed was, "Why have my colleagues been chiefly interested in the psychology of mental ill-health, the study of the sick and disturbed? Why has there been so little study of the psychology of the mentally and emotionally healthy person?" He believed that if someone could do this, he might discover goals toward which we could strive -- goals which would make us more fully functioning, more happy, and more useful to mankind.

With that in mind, he made an intensive search for those people, past or present, who seemed to lead full, rewarding, and happy lives. He called these individuals "self-actualized" -- meaning that they seemed to have actualized themselves to the fullest or almost to the fullest extent. He studied them in detail, trying to find the qualities they had in common with each other, and this study has been of enormous value.

There is now a Fourth Force emerging, called Transpersonal Psychology. This force is concerned with ultimate states of being, and assumes that man's tendencies toward ultimate meaning cannot be reduced to lower animal drives. The individuals who are involved in Transpersonal Psychology study areas such as wonder, bliss, self-transcendence (rising above oneself), ultimate meaning, and mysticism. From the latter two items, it can be seen that they are delving into philosophical and religious spheres.

EXISTENTIAL PSYCHOLOGY

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EXISTENTIAL PSYCHOLOGY

ROLLO MAY

Reality is not abstract thought, theories, etc., but experience as men live it.

Existentialism means centering upon the EXISTING person -- it is the emphasis on the human being as he is emerging, becoming. The opposite view sees human beings in terms of forces, drives, conditioned reflexes, etc.

The more accurately you describe a given mechanism, the more you lose the person who has the mechanism.

Modern science tends to make man over into the image of the machine and thus dehumanize him.

"Being" is the individual's unique pattern of potentialities. The "unconscious" is not a reservoir of impulses, thoughts, and wishes that are unacceptable to the individual or to his culture, but rather *those potentialities for knowing and experiencing that he cannot or will not actualize.*

Anxiety arises not so much out of fear of insecurity or unfulfilled satisfactions, but rather out of one's fear of one's own powers, and the conflicts that arise from that fear.

The underlying structure of a man is much greater than the sum total of all his mechanisms, forces, drives, etc. This structure is his *pattern of potentiality.*

No matter how great the forces victimizing a man, he has the capacity to KNOW that he is being victimized, and thus to decide how he will RELATE to his fate. He never loses the power to take some stand, to make some decision.

To achieve individuality, man must face the conflicting realities of our world -- face and meet them directly.

A. H. MASLOW

We are faced with the total collapse of all sources of values outside the individual. Political democracy and economic prosperity do not in themselves solve any of the basic problems. There is no place else but inward, to the self, as the source of values.

The authentic person not only transcends himself, but also his culture and his society.

Verbal, analytical rationality is very limited. Raw experience is much more basic and important.

The future is unknown -- therefore all habits, defenses, etc., are of doubtful value because they are based on past experience. Only the flexibly creative person can really manage future, only the one who can face novelty with confidence and without fear. Defenses are tricks used to avoid the anxiety of novelty by pretending or assuming the future will be like the past.

What we call normal or average today is characterized by a general phoniness, a living by illusion and fear -- and seen through the eyes of existentialism, is sickness. The loss of illusions and the discovery of one's identity, though painful at first, can be ultimately exhilarating and strengthening.

HERMAN FEIFEL -- DEATH

Death is something that happens to each one of us. Even before its arrival, it is an absent presence. It is near the center of the human condition -- an essential part, rather than the mere end of life.

Only by integrating the concept of death into the self does a genuine existence become possible. The price for denying it is undefined anxiety and self-alienation. To completely understand himself, man must become aware of a personal death. Life is not comprehended truly or lived fully unless the idea of death is grappled with honestly.

GERALD SYKES (FROM THE HIDDEN REMNANT)

Anxiety and guilt are implicit in man's condition, rather than primarily neurotic. Existentialism was a protest against the way human beings were compartmentalized by rationalism during the 19th and 20th centuries. This kind of rationalism results in self-estrangement. The existentialists protested against the tendency to treat man as an object to be calculated and controlled, made into anonymous units to fit like robots into the vast industrial and political collectivisms of our day.

Anxiety, guilt, death, despair and meaninglessness are inherent in the nature of man and must be faced squarely, as inescapable parts of life. Only when we face them with courage and clarity can we hope for real joy or real solidity or achievement -- unless we prefer well-adjusted conformity and its rewards, together with the neurosis and self-deception that hide beneath it.

In trying to gain power over nature, man has become estranged from it. The result is a vague despair of gaining any real relationship with the natural world, including one's own body.

CREATIVITY, DEFENSE MECHANISMS, AND NEUROTIC BEHAVIOR

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SUGGESTED READING

Self-Analysis	Karen Horney
Neurosis and Human Growth	Karen Horney
The Mature Mind	Harry Overstreet
The Neurotic Personality of our Time	Karen Horney
Understanding Fear	Bonaro Overstreet
The Art of Loving	Erich Fromm
The Transparent Self	Sidney M. Jourard
On Becoming a Person	Carl Rogers
Toward a Psychology of Being	Abraham Maslow
Levels of Knowing and Existence	Harry L. Weinberg
Games People Play	Eric Berne
A Guide to Rational Living in an Irrational World	Albert Ellis and Robert Harper.

CREATIVITY: Whenever we help to bring about, either in ourselves or in others, a change in the direction of further growth, we are being creative.

CHILDHOOD BLOCK TO CREATIVITY: The child starts by being completely dependent on others. When he begins to assert himself with his first feelings of "self" or "I am a separate individual," his expressions and behavior are likely to seem belligerent or rebellious and usually he is "put in his place." His "self" or uniqueness as a particular individual is squelched rather than given room and direction to grow.

HEALTHY PERSONALITY

1. Absence of anxiety
2. Realistic evaluation of oneself and one's environment
3. Realistic values
4. Good interpersonal relationships
5. Ability to love and have empathy for others
6. Flexibility - ability to accept and adapt to change
7. Emotional independence - no need for emotional support from others
8. Respect for oneself and others
9. Acceptance of self and others (including shortcoming and mistakes)
10. Ability to accept frustration and disappointment
11. Sense of individuality - capable of conforming to the norms of society, and, at the same time, capable of deciding when it would be undesirable to conform.
12. A sense of independence - ability to work toward own goals without being constantly concerned about what others may think or say
13. A sense of responsibility - taking into account the consequences of own actions and being sensitive and responsive to the needs of others
14. Realistic goals
15. Personal values and philosophy of life
16. Problem-solving attitude

DEFENDING AGAINST FEELINGS OF INADEQUACY AND INSECURITY

DEFENSE MECHANISMS (First line of Defence)

Defense mechanisms are used to guard against feelings of inadequacy, rejection, failure, frustration arising from inability to solve a problem or satisfy a need, impaired self-esteem, feelings of guilt and anxiety.

To overcome these disturbing feelings we may accept the failure or rejection; we may try to solve the problem or satisfy the need through renewed efforts; OR we may resort to defense mechanisms.

A defense mechanism is a means of DENYING THE REALITY of failure or frustration (and the accompanying unpleasantness) by overlooking or ignoring it and replacing it with something else.

A defense mechanism is an ego-sparing or anxiety-relieving alibi that attempts to explain away failure - it is always SELF-DELUDING. All people use them to some degree, but when they become a way of life, the individual becomes maladjusted.

VALUES OF DEFENSE MECHANISMS: Preserve self-esteem, protect against self-devaluation and anxiety. May work satisfactorily until the mechanism becomes exaggerated to the point where it defeats its purpose.

1. Compensation: Trying to offset a real or imaginary defect in one area by substituting a skill or quality in another; covering up a weakness by substituting another trait: over-gratifying a need or desire in one area to make up for frustration in another.

2. Rationalization (sour grapes): Converting the unattainable into the undesirable; trying to justify behavior, beliefs, inconsistencies, failures, etc. by blaming circumstances, tools, other people, etc.

3. Identification: Person who cannot achieve his own goals (or has none), tries to enhance his self-esteem by identifying himself with another person or a group, hoping to share their achievements or fame.

4. Projection: Assigning to others those characteristics, thoughts, desires, feelings, etc. which we cannot tolerate in ourselves; blaming others for own shortcomings and mistakes.

5. Daydreaming: Gratifying frustrated desires in imaginary achievements, withdrawing from reality into a private dream world that protects one from the threat and anxiety of unsolved problems and disturbing situations.

6. Withdrawal: Removing oneself physically from the disturbing situation.

7. Repression: Unconsciously preventing dangerous thoughts and impulses from entering awareness.

8. Regression: Retreating to earlier, less mature forms of behavior; psychological retreat into the past to escape from present threats or conflicts.

9. Conversion: Instinctive and unacceptable wishes turned into physical illness or symptoms, which can protect against humiliating memories and feelings.

10. Displacement: Shifting of emotion, usually hostile, from the person or situation with which the emotion was originally connected, to another safer person or situation.

11. Introjection: Adopting the behavior, standards, values, or attitudes of others, in order to make these other people less threatening.

12. Sublimation: Substituting socially-accepted means of satisfying impulses for socially-unacceptable means.

13. Reaction Formation: Behaving ina way that is the opposite of that which the individual feels; compensating for negative impulses by substituting behavior that will best mask these impulses.

DEFENSE MECHANISMS ARE UNDESIRABLE WHEN they jeopardize the physical or mental welfare and growth of the individual or of society. They cease being adjustive when they obscure the source of a conflict or the real nature of a problem, when they lead to cumulative maladaptations, when they prevent a person from making an objective analysis of himself in relation to his problem and blind him to the possibility of alternative courses of action.

THE NEUROSES (Second line of Defense)

If the first line of defense, the defense mechanisms, cannot sufficiently protect against feelings of insecurity and inadequacy, we may mobilize a second line of defense - the neuroses. These are disorders reflected in ways of thinking, feeling, and behaving, produced by severe emotional tensions that the defense mechanisms could not adequately control.

Neurotic symptoms are attempts to cope with inner conflicts and out pressures that are threatening. (Defense mechanisms may continue to be used in neurotic behavior.)

NEUROTIC BEHAVIOR: unconscious, inappropriate, rigid; not endangering or requiring hospitalization. The neurotic is in touch with reality, recognizes the inappropriateness of his behavior, but doesn't understand it, and has disturbed relationships with others.

1. Anxiety reactions: Difficulty with breathing, heart palpitations, sweating, mouth-dryness, dizziness; may be a chronic state of fear or temporary attacks of intense fear.

2. Phobic reactions: Adopting an unreal outside danger, which causes less pain and anxiety than an unconsciously-feared internal danger. This is usually a danger left over from childhood, the memory of which has been deeply buried because of the fear of punishment for thinking or doing something taboo. The fear becomes exaggerated and illogical and attaches to a specific person(s), object(s), or situation(s).

3. Obsessive-compulsive reactions:

   Obsession: persistent repetition of a disquieting, unwanted thought.
   Compulsion: an act performed without knowing why or without con-

sciously wishing to do it.

4. Dissociate reactions: thinking, feeling and behaving become separate from consciousness and function as separate activities.

   a. amnesia - may be partial or total
   b. fugue (flight) - prolonged period of amnesia during which the person usually leaves home and job and beings a new life with a new name and identity.
   c. multiple personality (Jekyll-Hyde) - individual cannot integrate his contradictory traits or his various roles.

5. Conversion reactions: anxiety and emotional conflict are converted into physical symptoms of disease or disability.

   a. hysterical sensory disturbances - deafness, blindness, etc.
   b. hysterical paralysis - limbs, voice, any part of the body
   c. motor disturbances - loss of muscular control, tics, tremors, etc.

6. Repressive reactions: withdrawal from stimulation, lack of interest, loss of initiative, feelings of hopelessness or worthlessness, self-doubt; dejection, pessimism, discouragement.

7. Hypochondriac and neurasthenic reactions: extreme preoccupation with how one feels physically.

   a. hypochondria: concern over digestion, heart, lung, etc. difficulties.
   b. neurasthenia: feelings of being tired, exhausted, weak, cannot concentrate, easily upset by difficulties, very irritable.

   Both of these provide a "physical" excsue for not trying things which may fail - both are protection against the admission of inadequacy or failure.

CAUSES OF NEUROTIC BEHAVIOR:

1. Heredity: difficult to differentiate between inherited and acquired characteristics - assumption is that it is "learned" behavior.

2. Past experiences: experiences from earliest childhood help to shape the way we think, feel and behave, and so influence our behavior toward normality or neuroticism. In addition, certain specific experiences may promote defensive, maladaptive, or neurotic behavior. A child who has had considerable illness may, in times of stress, fall back on illness and physical complaints in trying to solve his problems; overstrict training in cleanliness, punctuality, rules, etc. may result in obsessive-compulsive behavior; rejection may result in a person's wanting love or attention intensely but avoiding it in order to avoid another rejection.

3. Contemporary situations: an individual may function quite adequately unless special stress or pressure appears - serious quarrel, serious financial problem, loss of job, war, etc.

FUNCTIONS SERVED BY NEUROTIC BEHAVIOR

Neurotic behavior patterns are unconscious attempts to deal with conflict situations, ways of dealing with anxiety and conflict. The neurotic cannot find relief from anxiety through normal and acceptable channels. Neurotic complaints may protect a person from taking on problems that are beyond his ability - he shifts the responsibility for his failure or inadequacy to some physical defect over which he cannot be expected to have any control, and thus maintains his self-respect; the guilt-ridden person who has a hand-washing compulsion does not really free himself from his guilt feelings, but he does reduce them temporarily.

Although it does reduce tension temporarily, neurotic behavior may at the same time aggravate the underlying causes of the tension - a person who does not get along well with others may alienate them further by compulsive or obsessive behavior.

BECOMING A PERSON

1. Develop an awareness of self - become CONSCIOUS of self. This is not self-consciousness (which implies standing outside oneself, looking at oneself, and usually criticizing oneself.) Consciousness of self makes for spontaneity - self-consciousness breeds inhibition, excessive control, etc.

    a. Rediscover, clarify, and accept one's feelings. Many feelings are considered non-acceptable - two most strongly disapproved of are RESENTMENT and HATRED. When a child's freedom is interfered with, he becomes resentful - if he is not permitted to express his resentment, it becomes bottled - up - usually develops into hate - both feelings often become buried as he feels it is dangerous to have these feelings toward people he needs.

    b. Rediscover one's body and body sensations.

    c. Discover and identify with subconscious aspects of oneself as comfortably as possible - be sympathetic and accepting of expressions of one's dreams. First step toward utilizing the potential of the subconscious is to become aware of one's resentment - to accept and feel it. This does not mean to ACT on it - merely to EXPERIENCE it.

    d. Develop the objectivity that enables us to study ourselves critically and dispassionately, with a minimum of self-deception and camouflage - what motivates us, how we communicate with others, how sensitive we are to the needs of others, how certain conditions affect our emotional ups and downs. Become aware of strong points so as to utilize them to better advantage, discover weak points and habits which are inappropriate and do not solve problems; how we affect our environment and how it affects us, own needs, desires, ways of doing things.

All of the foregoing lead to experiencing oneself - then one finds the answer to "what do I want," "what is important to me," etc., instead of "what SHOULD I want,", "what is important to the neighbors," etc.

2. Try to heighten perception of the environment and other people. Aim for sensitivity to the needs and feelings of others, notice how people behave under certain conditions. Acceptance of others (and self), including shortcomings and mistakes, is fundamental in the ability to love.

HORNEY'S THEORY OF NEUROSIS:

The foundations of neurosis are laid in childhood when, due to influences from an unfavorable environment, the individual is beset by pervading anxiety and by feelings of helplessness and isolation in a hostile world. His contact with others is then not sufficiently free for him to express his real feelings. He is primarily concerned with lessening his feelings of anxiety and his behavior and contacts will reflect this.

The result is that his basic drives, which in the healthy individual serve real interests, become compulsive reactions aimed at lessening his feeling of anxiety, without regard for real wants and interests. As the individual grows in years, the neurosis grows with him, unless corrective steps are taken.

Each main component of his basic anxiety generates a protective compulsive drive. The helplessness leads to a compulsive need for affection; the feeling of hostility in the environment is counteracted by a need to dominate; the feeling of isolation leads to a protective withdrawal, a moving away from people and from awareness of emotional conflicts. Since these activities are incompatible, they give rise to a basic conflict.

He is then caught in a network of defenses which operates automatically and unconsciously. Consequently much of his energy is used to support a system which obstructs his fuller living and deprives him of available forces. The ensuing impoverishment of his personality brings about self-contempt, compensatory strivings in the form of living in fantasy in order to maintain a flattering picture of himself, and a diffuse envy and hostility toward others.

EXISTENTIAL THEORY OF NEUROSIS:

Anxiety and guilt are implicit in man's condition, rather than primarily neurotic. Every person is centered in himself and an attack on this center is an attack on his existence itself. Neurosis is not a deviation from our theories of what a person should be, but rather the method a person uses to preserve his own center, his own existence.

His symptoms are ways of shrinking the range of his world in order that the centeredness of his existence may be protected from threat, a way of blocking off aspects of the environment so that he may then be adequate to the remainder.

Neurosis is an ADJUSTMENT, and that is just its trouble. It is a necessary adjustment by which centeredness can be preserved - a way of accepting _non-being_ in order that some little _being_ may be preserved. In most cases, it is a boon when this adjustment breaks down - that is when the individual goes for help.

All persons have the need and possibility of going out from their centeredness ... to participate in other beings. This always involves risk - if he goes out too far, he loses his own centeredness - his identity. If the neurotic is so afraid of loss of his own conflicted center that he refuses to go out, and holds back in rigidity, and lives in narrowed reactions and shrunken world space, his growth and development are blocked.

THIS IS THE PATTERN IN NEUROTIC REPRESSIONS AND INHIBITIONS.

BUT, it may well be in our culture of conformity and the outer-directed man, that the most common neurotic pattern of our time takes the opposite form - the dispersing of one's self in participation and identification with others until one's own being is emptied.

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MASLOW*

MOTIVATION

The individual is an integrated whole -- when he is hungry, it is not only his stomach that hungers -- HE needs food, not just his stomach. Many changes occur in a hungry person -- changes in his perception, memory, emotions, thinking, etc. He is hungry all over -- he is different from what he is at other times.

Hierarchy of Needs

There is an ascending hierarchy of needs; as each order is satisfied, it releases the needs of the next order.

1. Physiological needs -- food, water, oxygen, sleep, sex.
2. Safety needs -- security from threat and danger.
3. Belongingness and love needs.
4. Esteem needs -- respect, self-respect, prestige, etc.
5. Growth and self-actualization needs.

Physiological Needs: Often, though not always, can be isolated, which is not true of the other needs. They are of primary importance. When one of these is present to a high degree, all other needs are dormant and do not emerge until the ongoing need is satisfied. The organism functions entirely to satisfy this need when it is present -- it is the dominating factor in his view of the world and the future. He feels that if this need is satisfied, he will be content.

When the physiological needs are regularly gratified, they cease to exist as active determinants of behavior and remain only as potentials in that they may emerge again to dominate the organism if thwarted. A want that is satisfied is no longer a want. When these needs are relatively well gratified, the next needs that emerge are the

Safety Needs: These operate like the physiological needs, although to a lesser degree. The child does better and feels safer in an organized, somewhat structured world than in the opposite. A rejected child will cling to its rejecting parent merely to satisfy his need for safety. The average child generally prefers a safe, orderly, predictable, organized world which he can count on, and in which the unexpected, unmanageable or other dangerous things do not happen, and in which he has all-powerful parents who protect and shield him from harm.

Safety needs are not seen in the average man in our culture; they appear in the neurotic and in the economic and social underdogs.

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* Adapted from Abraham H. Maslow, *Motivation and Personality*, (Second Edition). New York: Harper and Row, 1970.

Safety needs in an adult appear in the compulsive-obsessive neurosis -- he tries frantically to stabilize and organize the world so that no unmanageable, unexpected, or unfamiliar dangers will ever appear.

Belongingness and Love Needs: If the physiological and safety needs are fairly well gratified, needs for love, affection and belongingness appear. In our society the thwarting of these needs is the most common core in cases of maladjustment. All statements relating to the previously mentioned needs apply to the love and belongingness needs.

Esteem Needs: All people in our society have a need for a stable, firmly-based, usually high evaluation of themselves, for self-esteem and for the esteem of others. Satisfaction of these needs leads to feelings of self-confidence, worth, strength, being useful and necessary. Thwarting of these needs produces feelings of inferiority, weakness, helplessness, and these feelings give rise to either basic discouragement or compensatory or neurotic trends. The most healthy form of self-esteem is based on *deserved* respect from others, rather than on external fame or unwarranted adulation.

Self-actualizing Needs: When all the foregoing needs are fairly well gratified, a new discontent and restlessness develops unless the individual is doing what he is fitted for. Man has a tendency to realize his potentials -- to become more and more what he is, everything that he is capable of becoming.

Need to Know, Understand, Explain, Satisfy Curiosity: The healthier the individual, the more eager he is to explore the unknown, the mysterious, the unorganized, the unexplained. Usually the unhealthy personality deals only with the known -- he feels safe there. The achievement of knowledge, of an insight, is usually a gratifying experience. (Children do not have to be taught to be curious -- some are taught the opposite.)

The hierarchy of needs is not rigid. Some people seem to need self-esteem more than love, although it is possible they are seeking self-esteem as a substitute for love. Some creative people need creativeness more than any other need. Some people have very low levels of aspirations, the higher goals may disappear forever, he who has experienced life at a very low level may continue to be satisfied for the rest of his life with fulfilling his primary needs. Some people who have been starved for love in their early months of their lives have lost forever the desire and ability to give and receive affection. A need doesn't have to be fully satisfied for the next need to emerge; the need need may appear when the preceeding one is partially fulfilled. Most people are satisfied with the following:

Physiological needs	85%
Safety needs	70%
Love needs	50%
Self-esteem needs	40%
Self-actualizing needs	10%

These needs are more often unconscious than conscious, the former being more important as motivating forces.

The behavior of an individual is often determined by several needs.

Thwarting of unimportant desires produces no undesirable results in the individual; thwarting of basically important needs does produce psychopathological results. A conflict or frustration is not necessarily pathogenic, but only when it threatens or thwarts the basic or the partial needs that are closely related to them.

A healthy man is primarily motivated by his needs to develop and actualize his fullest potentialities and capacities; he has no needs for esteem, love, safety, etc. -- they have been fully satisfied. The man who HAS these needs in any active, chronic sense is simply an unhealthy man just as if he lacked salt, calcium, etc.

The strong, healthy person who had all his early chronic safety, love, etc. needs fully fulfilled, no longer needs them -- he is capable of withstanding loss of love and popularity.

Some consequences of satiating a need:

1. Independence of and some disdain for the old satisfiers and goals; new dependence on newly-emerged satisfiers and goals.

2. Changes in interests, values, attention, perception, learning, etc.

3. New interests, satisfiers, and needs are higher in the scale. The easiest technique for releasing the organism from the bondage of the lower, more selfish needs is to satisfy them.

4. Gratification of any basic (not neurotic) need helps to determine character formation and tend towards improving, strengthening, and healthy development of the individual.

Differences between higher and lower needs:

1. Physiological and safety needs are deficiency or D-needs and must be optimally fulfilled by the environment in order to avoid sickness or any other feeling of ill-being. They are basic because
    a. The deprived person yearns for their gratification persistently.
    b. Their deprivation makes the person sicken and wither.
    c. Gratifying them is therapeutic, curing the deficiency-illness.
    d. Steady supplies forestall these illnesses.

2. Growth and self-actualizing needs are becoming or B-needs.

3. Higher needs came later in evolutionary development.

4. The higher the need, the longer its satisfaction can be postponed and the less imperative it is for physical survival at the moment.

5. Gratification of the higher needs leads to increased capacity for love and a truer individualism. Capacities like intelligence, love, etc., clamor to be used and cease their clamor only when used sufficiently.

6. Gratification of the higher needs produces more desirable and longer lasting results, more serenity, and happiness.

7. Pursuit and gratification of the higher needs have desirable social consequences -- higher form of selfishness (unselfish selfishness).

Healthy people have sufficiently gratified their basic needs for safety, belongingness, love, respect, etc., so that they can now satisfy their growth needs for self-actualization, integration, individualism, realizing all potentials. The individual does not know this -- his only concern is his ongoing need -- he feels that if that is fulfilled, he'll be content forever — he does not know that its gratification will open the way for his next higher need.

Impulse: Most theories of motivation regard needs, drive, motivating states as annoying, irritating, unpleasant, undesirable, something to get rid of; and motivated behavior of goal-seeking as techniques for reducing those discomforts. Freudian psychology is built upon the same attitude toward motivation adding that impulses are dangerous and to be fought. This may apply with sick people who suffer from bad experiences with their needs, gratifications, and frustrations. They find desire or impulse a nuisance or even a threat; they handle it badly, therefore try to get rid of it, deny it, avoid it (defense mechanism).

This contention is sometimes accurate for physiological needs, for safety, love, respect needs; they are problem-creators, especially for those who have had unsuccessful experiences at gratifying them and for those who cannot now depend on getting gratification.

However, one can accept and enjoy one's needs, and welcome them into consciousness if past experience with them has been rewarding and/or if present and future gratification can be counted on. This is especially true of self-actualizing impulses such as creativity. These impulses are desired, welcome, pleasurable.

Effects of gratification: Associated with the negative attitudes toward need is the concept that the primary aim of the organism is to get rid of the annoying need and thus achieve a cessation of tension, states of rest, lack of pain. This theory is very inadequate as it does not take into account the dynamic principle of growth -- as each need is fulfilled, the next higher appears, so cessation of tension may be very brief. In a man who is growth-motivated, gratification breeds increased rather than decreased motivation, heightened rather than lessened excitement; instead of coming to rest he becomes more active. Also the activity to achieve the means becomes pleasurable instead of just goal-seeking.

Clinical effects of gratification: Satisfaction of D-needs avoids illness; satisfaction of B-needs produces positive health.

Enjoyable effects of gratification: Satisfaction of D-needs brings relief; satisfaction of B-needs brings ecstasy.

Attainability of goals: D-need gratification tends to be episodic and climactic, with sometimes a sharp letting down when fulfilled. B-need gratification is a continued, upward or forward development--it is endless and can never be attained or satisfied completely.

Species goals and individual goals: D-needs are sharpened by the human species (and to some extent by other species). Self-actualization is different for each person. Species needs usually must be fairly well satisfied before real individuality can develop fully. In species needs, development is determined from without -- in individual growth needs, development is determined from within.

Dependence on and independence from the environment: Since a person's safety needs can only be satisfied by others he must be other-directed, sensitive to their approval, affection, and good will. He must adapt, adjust, change to fit the external situation since he depends on it. Therefore he is afraid of the environment -- it may fail or disappoint him. (This anxious dependence breeds hostility -- also he loses some degree of freedom.)

The self-actualizing person is far less dependent and is self-directed -- his determinants are inner -- other people may hamper him. He is less ambivalent, anxious, hostile, demanding toward others or of others; he doesn't need honors, prestige, rewards from them.

Interpersonal relations: The D-motivated person does not see others as they are, but as they must be useful to him. They are not seen as whole persons; what is not related to his needs he overlooks or perceives as boring, irritating, or threatening. Often they are interchangeable. The G-(growth) motivated person sees others as unrewarding, useless for his needs, unique, independent, individuals rather than tools. His love or admiration is based on the qualities in others, not as they are useful to him.

Ego-centering and ego-transcending: The G-M person has a strong ego and yet easily transcends it; he becomes problem-centered, self-forgetful, spontaneous. The D-M person is self-conscious, egocentric.

Learning and personality change: Learning theory is largely based on D-motivation; goal objects usually external to the organism, learning as the best way to satisfy a need. The G-M person needs little from the outside world in learning about himself, helping the steady growth of his personality becoming integrated and consistent. Change becomes much less and acquisition of habits or associations one by one and much more a total change of the total person -- new person rather than the same person with some habits added like new external possessions.

D-M and G-M perception: Since a G-M person's perception is more concrete and less selective, he more easily sees the intrinsic nature of the percept; he perceives its opposites, contradictions, incompatabilites simultaneously. A D-M person sees classes, sharp boundaries, polarites (good or bad, never both). Because the G-M person does not have to abstract need-gratifying qualities nor see the other as a tool, it is much more possible for him to be nonvaluing, nonjudging, noninterfering, noncondemning.

DEFENSE AND GROWTH

Growth takes place when the next step forward is subjectively more delightful, more satisfying than the last; not because it is good for us, we are told to do it, we will live longer, it is good for the species, it is logical, we will get external rewards. Through growth we learn what we are good at, what we really like or dislike, what our tastes, judgments and capacities are -- we discover the self.

The steps of the healthy infant are spontaneous -- exploring, manipulating, experiencing, choosing, enjoying. What interferes is the regressive power of ungratified D-needs, the attractions of safety and security, the functions of defense and protection against pain, loss, fear, and threat.

Everyone has BOTH sets of forces within him; one set clings to safety and defensiveness out of fear of taking chances, independence, freedom, separateness, risking what he already has. The other set of forces impels him forward toward wholeness and uniqueness of self.

Thus the process of growth is a never-ending series of free choices, confronting each one at every point throughout his life, in which he must choose between the delights and safety of growth, dependence and independence, regression and progession, immaturity and maturity.

If the choice is really free, not an outgrowth of a D-need, if the chooser is not too sick or frightened to choose, he will choose wisely, in a healthy and growing direction, more often than not.

Growth forward occurs in little steps, each step forward made possible by the feeling of being safe, of operating out into the unknown from a safe home port; daring because a secure retreat is available.

If the child has a choice between giving up safety and giving up growth, he will give up growth, and this choice is right for him at that time, even though it cuts him off to some degree from his self. Safety is a most basic need for children--much more necessary than independence and self-actualization. He can be helped to grow by an environment which satisfies his basic needs for safety, belongingness, love and respect, so that he feels unthreatened and spontaneous and thus dares to choose the unknown. He can also be helped by making the growth choice positively attractive and less dangerous, and by making the regressive choice less attractive and more costly.

The environment, teacher, parent, do not give the individual his creativeness, spontaneity, selfhood, etc. They permit, foster, or encourage what exists in embryo to develop, grow, become real.

NEED TO KNOW AND FEAR OF KNOWING

One of the needs involved in self-actualization is the need to know (to explore, be curious, etc.). However, there are many deterrents to the gratification of this need.

A great cause of much psychological illness is the fear of knowledge of oneself -- one's emotions, impulses, memories, capacities, potentialities, etc. This fear tends to spread so that there is a fear of knowledge in general without discriminating too sharply between the inner world of the self and the outer world. This fear is defensive -- a protection of self-esteem. We tend to be afraid of any knowledge that might cause us to feel inferior, weak, evil, shameful, etc. We protect ourselves and our ideal self-image with defenses which block unpleasant or dangerous truths.

We also tend to evade knowledge of our creativity, highest potentialities, etc. We may be fearful of the responsibility involved or the discovery that we fall short of some wish or ideal. Sometimes knowledge is felt to be too dangerous and should be left for a few special people -- if we knew, we might have to do something about what we find out. Creativity may be avoided because it may bring loneliness. Many bright women avoid knowledge and deny their need to know, because it may interfere with what they have been told is "femininity." Children may identify curiosity with trespass upon adults and adults often squelch curiosity in children, giving the latter a feeling that knowledge would make them less lovable. The bright student is often discouraged in his search for knowledge by the busy or disinterested teacher.

In spite of all these deterrents, children and adults continue to probe, explore, seek knowledge, so there must be a need. It is higher in the hierarchy than safety needs. It also may have an anxiety-reducing value -- if we feel fearful and threatened, we may get rid of the fear by exploring and finding out what the threat is. This knowledge is not nearly as satisfying as that of the anxiety-free person who can be more bold and courageous, and can explore and theorize for the sake of knowledge itself. This kind of knowledge brings varying degrees of pleasurable rewards, ranging from illumination to ecstasy.

SELF-ACTUALIZATION

In order to learn as much as possible about self-actualization, Maslow did a series of studies, selecting his subjects according to the following criteria:

> Negative criteria: No neurosis, psychopathic personality, psychosis, or strong tendencies in these directions.
>
> Positive criteria: Full use and exploitation of talents, capacities, potentialities, etc. All subjects felt safe, unanxious, accepted, loved and loving, respect-worthy and respected, and had worked out their philosophical or religious bearings.

Perfection was not sought as it was assumed it could not be found.

Full cases: 3 fairly sure and 2 highly probable contemporaries (anonymous).
2 fairly sure historical figures (Lincoln in his last years and Thomas Jefferson).
6 highly probable public and historical figures (Einstein, Eleanor Roosevelt, Jane Addams, William James, Spinoza).

Partial cases: 5 contemporaries who fell short but who could yet be used for study (anonymous).
7 historical figures in the same category (Walt Whitman, Henry Thoreau, Beethoven, F.D. Roosevelt, Freud).

Potential or Possible cases: G.W. Carver, Eugene V. Debs, Albert Schweitzer, Thomas Eakins, Fritz Kreisler, Goethe.
20 younger contemporaries who seemed to be developing toward self-actualization.

Almost all people perceive most of the time in a deficient way; they compare, judge, relate, approve, use. Self-actualization is an episode, or a spurt in which the powers of a person come together in a particularly efficient and intensely enjoyable way and in which he is more integrated, more open for experience, more idiosyncratic, more perfectly expressive or spontaneous, more fully-functioning, more creative, more humorous, more ego-transcending, more Being. Self-actualizers have these episodes more frequently, intensely, and perfectly than do average people and in their day-to-day living they are likely to be less dependent on D-need gratification.

SA frees the person from the deficiency problems of youth and the neurotic problems of life. It is not a static, unreal, perfect state in which all human problems are transcended. He deals with real guilt, sadness, loneliness, healthy selfishness, courage, responsibility, etc.

Creativity in SA People

It is different from the kind of creativity found in poets, artists, etc. (Some of these were and are definitely unhealthy, unhappy, etc.) It is not only a product but a process, an activity, an attitude, and springs much more directly from the personality than "special talent creativeness." It seems to be an ability to do anything creatively.

SA persons see the fresh, raw, concrete, as well as the generic, abstract, classification. He lives much more in the real world of nature than the verbalized world of concepts, abstractions, expectations, beliefs, and stereotypes that most people confuse with the real world -- he is open to experience.

He is more natural, able to express ideas and impulses without fear of ridicule; has an innocent freedom of perception, uninhibited spontaneity and expressiveness. This is so characteristic of children that we can conclude that all people had it originally but it became lost or buried or inhibited as they became enculturated.

He is relatively unfrightened by the unknown, the puzzling, the mysterious; may even be attracted to these qualities. He does not cling to the familiar; neglect, deny, or run away from the unknown, or pretend that it is known; does not organize or dichotomize it prematurely.

He does not need safety, definiteness, order; can be comfortably sloppy, chaotic, vague, doubtful, inaccurate, when the total situation calls for it. Doubt, uncertainty, abeyance, of decision which is for most people a torture, can be for him a pleasantly stimulating challenge.

He is less afraid of what others would say, demand, or laugh at; less need for and less hostile against them. Does not fear his own impulses, emotions, thoughts; more self-accepting and integrated.

He can superficially accept conventions, but privately be casual and detached about them. He can reject the stupidities and imperfections of the culture, and fight vigorously when he thinks it necessary. He has his own inner criteria.

He has resolved the civil war between his inner depth forces and his defense and control forces, so more of himself is available for use, enjoyment, creation. He wastes less time and energy protecting himself from himself. With his acceptance of his deeper self, it becomes more readily available for creative use.

The "normal," common sense, well-adjusted man continually and successfully rejects much of the depths of human nature because he feels it may be dangerous, but he loses much, for in these depths are his joys, ability to play, love, laugh, and his creativity. His imagination, intuitions, softness, emotionally tend to become strangulated or distorted.

We confuse primary processes with forbidden impulses (although they are not as dangerous). We do not repress or censor them; rather we forget or turn away from them as we try to adjust to a harsh reality which demands a purposeful striving rather than dreaming, playing, etc. Education, which can do little to relieve repression of instincts, may be able to help the person accept and integrate the primary processes into preconscious and conscious life through art, poetry, dancing, etc.

SA creativity seems to come from fusion of primary and secondary processes rather than from working through repressive control of forbidden impulses and wishes. It is probably that defenses arising out of fears of these forbidden impulses also push down primary processes in a kind of total undiscriminating panicky war on ALL THE DEPTHS.

SA creativity stresses the personality rather than its achievements, qualities like boldness, courage, freedom, spontaneity, integration, self-acceptance, the Being quality of the person rather than his problem-solving or product-making quality.

Imperfections of SA People

Imperfections of SA people can have silly, wasteful, or thoughtless habits; can be boring, stubborn, irritating; can have vanity, pride, partiality to their own productions, family, friends, and children; can have temper tantrums; can be ruthless (since they are very strong) and can be very cold when it is necessary or called for; out of kindness they may become involved with bores, neurotics, scoundrels, parasites, etc.

SA Growth

There seems to be evidence that the human being is so constructed that, if his D-needs are satisfied, he presses toward fuller being and toward what most people call good values -- serenity, kindness, courage, honesty, love, unselfishness, and goodness.

Characteristics of the healthy human being:

1. Clearer, more efficient perception of reality.
2. Acceptance of self, others, and nature.
3. More open to experience.
4. Increased spontaneity, expressiveness, aliveness, functioning.
5. Increased integration, wholeness, unity of the self.
6. A real self, firm identity, autonomy, uniqueness.
7. Increased objectivity, detachment, transcendence of self.
8. Problem-centered.

9. Democratic character structure.
10. Ability to love, feel, empathize, etc.
11. Independence from the environment and the culture.
12. Continued freshness of appreciation.
13. Philosophical, unhostile sense of humor.

SA Feelings

SA feelings are zest in living, happiness, serenity, joy, calmness, responsibility, confidence in own ability to handle stresses, anxieties, and problems. (Opposite feelings: self-betrayal, fixation, regression, lack of identity, anxiety, despair, boredom, inability to enjoy, introjected guilt and shame, emptiness, aimlessness, fears.)

PEAK EXPERIENCES

D-cognition -- cognition organized by deficiency needs
B-cognition -- cognition of Being

Characteristics of B-cognition in Peak Experiences

1. The experience or object tends to be seen as a whole, a complete unit, detached from relations, usefulness, expediency, purpose.
2. The percept is exclusively and fully attended to; figure is all, ground tends to disappear or merge with figure. D-cognition perceives the object as one of a class, or interrelated with and separate from its ground; it judges, evaluates, compares.
3. The world is seen as a Gestalt, not as something useful; D-cognition sees it as pertaining to and being used by himself and others.
4. The perception becomes richer with repeated exposures. D-cognizer becomes bored, attention wanders with repetition.
5. The perceiver is relatively ego-transcending, self-forgetful; can be unmotivated, impersonal, desireless; object-centered rather than ego-centered; self may disappear or fuse with the percept.
6. The experience is felt as a self-validating, self-justifying moment which carries its own intrinsic value with it -- it is not a means to an end.
7. Experiencer may become disoriented in time and space; he tends to vanish.
8. The experience is good and desirable, never felt as evil or undesirable; it needs nothing else -- it is complete, necessary, inevitable.
9. B-values appear -- wholeness, perfection, completion, justice, aliveness, richness, simplicity, beauty, goodness, uniqueness, effortlessness, playfulness, truth, honesty, reality, self-sufficiency. These overlap and fuse with each other.
10. B-cognition is passive, noninterfering, receptive rather than active; it is "choiceless or desireless awareness."

11. It creates an emotional reaction of wonder, reverence, humility, as before something great (sometimes a touch of pleasant fear of being overwhelmed); it may bring tears, laughter, or pain.
12. In some reports the whole world is perceived as a single, rich live entity; in others, one small part of the world is perceived as if it were all of the world; in both cases, the perception is of unity.
13. It is perceived with its many contradictions fused, transcended or resolved; selfish and unselfish, rational and irrational, concrete and abstract, etc.
14. At the peak, the perceiver is godlike in his complete, loving, uncondemning, compassionate and perhaps amused acceptance of the world, others, himself.
15. The percept tends strongly to be unique and nonclassified.
16. There is a complete though momentary loss of fear, anxiety, inhibition, defense and control; no delay of restraint; no fear of disintegration, death, insanity, pleasure, emotion.
17. As the essential Being of the other person or of the world is perceived, the perceiver comes closer to his own Being; this interaction seems to be both directions, for as he comes closer to his own Being he is able more easily to see the B-values in the world or in others. (As he becomes more unified, he tends to see more unity in the world, etc.)

Many of the above contrast sharply with our ordinary cognitions and reactions. We evaluate, control, judge, condemn, approve, laugh at rather than laugh with; we're concerned with usefulness, desirability; we make the world a means to our ends; thus we perceive only parts of it.

After Effects of Peak Experiences

1. May have some therapeutic effects of removing symptoms.
2. Can change the person's view of himself in a healthy direction.
3. Can change his view of the world, or of aspects of it.
4. Can change his view of and relations with other people.
5. Can release him for greater creativity, spontaneity, expressiveness, individuality.
6. He remembers the experience as a very important and desirable happening and seeks to repeat it.
7. He is more apt to feel that life is worthwhile, even if it is usually drab, painful, ungratifying, since he has become more aware that beauty, excitement, honesty, play, goodness, truth, and meaning exist.

Peak Experiences as Identity Experiences

The goals of identity, self-actualization, authenticity, seem to be a transitional goal of making the self stronger, and an end goal of obliterating the self.

1. He feels and looks more integrated, less at war and more at peace with himself, more harmoniously and efficiently organized with all his parts functioning nicely with each other.

2. He is more able to fuse with the world, going beyond and above selfhood and becoming relatively egoless.
3. He feels and appears to be at the peak of his powers -- "fully functioning"; more intelligent, perceptive, witty, strong, graceful; no longer wasting effort fighting and restraining himself; no wasted motion or energy.
4. He is not straining or struggling; appears calm and sure as if he knows exactly what he is doing, no doubts, hesitations, withdrawals.
5. He feels and looks more responsible, a prime mover, a self-determiner, sure of his worth, ability; looks trustworthy, reliable, dependable.
6. He is most free of blocks, inhibitions, cautions, fears, controls, self-criticism, reservations.
7. He is spontaneous, expressive, guileless, honest, unguarded, natural, immediate, uncontrolled, freely flowing.
8. More creative; improvises, creates out of nothing, more unexpected, novel, fresh, less premeditated. He drops his roles, becomes more truly himself, becoming more unique.
9. He is more here -- now, free of the past and future; can now listen better without expectations, preconceptions, constructs; does not compare what is here with what is not here in order to evaluate it.
10. Becomes more determined by inner laws rather than outer laws (where they differ). He grasps the nonself best by nongrasping -- letting it be itself, permitting it to live by its own laws rather than by his, just as he becomes most purely himself by refusing to let the nonself dominate his self and try to live by its laws.
11. He is nonstriving, nonheeding, unmotivated, no goals.
12. His expression tends often to become poetic, rhapsodic, etc.
13. He feels playful, happy; amused or delighted with the weakness and strength of the human being, transcending polarities.
14. He feels lucky, surprised, grateful, which often lead to an all-embracing love for everybody and everything; perceives the world as beautiful and good, is eager to repay; humility merges with pride.
15. There may be two kinds of physical reaction after peak experiences:
    a. excitement and high tension
    b. relaxation, peacefulness, stillness

Dangers of B-cognition Without D-cognition

1. Action and decision are unlikely since B-cognition is without judgments, condemnation, and evaluation. Since action and decision are necessary, D-cognition is needed to live in this world.
2. May make one less responsible, especially in helping others. The parent, teacher, therapist, must assume some responsibility in fostering growth, setting limits, disciplining, punishing, frustrating, etc.

3. Inaction and loss of responsibility lead to fatalism, loss of free will, which may be harmful to one's growth and self-actualization.
4. Inactive contemplation will likely be misunderstood by others who may suffer from it; it may be perceived as lack of interest, love, etc. and thus cause others to cease growing or regress.
5. It can lead to undiscriminating acceptance, to blurring of everyday values, loss of taste, too great tolerance. The truly SA person seems to be capable of being both therapist and policeman; usually compassionate and understanding, but also more capable of righteous indignation than the average person. Unless these are both present, effect can become flattened, reaction to people be bland, perception of and taste for real capacity, skill, superiority, and excellence be lost.
6. Others may misinterpret being perceived as "perfect." Total acceptance, love, etc. can be wonderfully growth-promoting and therapeutic, but it also can be perceived as a great demand to live up to unreal and perfectionistic expectations. The more unworthy and imperfect a person feels, the more he will misinterpret.

VALUES, GROWTH, AND HEALTH

Under free choice, mature and healthy people value not only truth, goodness, and beauty, but also the regressive, survival and/or homeostatic values of peace and quiet, sleep and rest, surrender, dependency and safety, protection from reality and relief from it, retiring into fantasy, etc. These latter are the "coasting" values as contrasted with the growth values -- he needs both. The higher needs of growth rest upon the continued gratification of the lower needs (which do not disappear, but become temporarily nonactive). The process of regression to lower needs is not always pathological, but also is absolutely necessary to the integrity of the whole organism, and required for the existence and functioning of the higher needs.

Lower needs and values are prepotent over higher needs and values most of the time for most people. Only the healthiest, most mature, most evolved persons choose higher values consistently more often (and if their life circumstances are good).

Man's higher nature, ideals, aspirations, and abilities rest not upon instinctual renunciation, but rather upon instinctual gratification.

Even the highest SA people are not exempt from the basic human predicament of being simultaneously ordinary and godlike, strong and weak, limited and unlimited, adult and child, fearful and courageous, progressing and regressing, yearning for perfection and afraid of it, being a worm and also a hero. These are not sets of dichotomies; our godlike qualities rest upon and need our animal qualities; adulthood includes the values of childhood and must build upon them. Higher values are integrated with lower values.

NEEDING LOVE AND UNNEEDING LOVE

The love need is a D-need -- if it is not available, severe pathology results; if it is available at the right time in the right quality, with the proper style, pathology is averted. The degree of the pathology depends on the state of the deficit.

D-love:	deficiency-love, selfish love.
B-love:	love for the Being of another person, unneeding and unselfish.

B-love is never sated, enjoyed endlessly, grows greater rather than disappears; an end rather than a means; can be vastly therapeutic; richer, higher, more valuable subjective experience than D-love; minimum of anxiety-hostility, more independent of the other, less jealous or threatened, less needful, more disinterested, more eager to help the other toward SA, more altruistic, generous, fostering; allows the other to grow, gives him a feeling of being worthy of love and respect, enhances his self-image. D-love is the opposite in most of the above; there is always some degree of anxiety-hostility.

PSYCHOPATHOLOGY

Neurosis is a deficiency disease, arising from inadequate or no gratification of needs for safety, belongingness, identification, close love relationships, respect, and prestige.

What stands in the way of growth, causes cessation and evasion of growth, fixation, regression, defensiveness? Why do so many people have no real identity, so little power to make their own decisions and choices?

1. Impulses toward self-fulfillment, though instinctive, are very weak and easily overwhelmed by habit, wrong cultural attitudes toward them, traumatic episodes, erroneous education.
2. Tendency in our culture to assume that human instincts are bad or evil, so we set up cultural institutions for controlling, inhibiting, suppressing and repressing this original nature of man.
3. In addition to the pressures foward toward health, there are also fearful-regressive pressures backward toward sickness and weakness.

Human Evil and Human Weakness

Human evil is largely, though not altogether, human weakness or ignorance -- forgivable, understandable, and also curable.

1. Self-knowledge seems to be the major path toward self-improvement, though not the only one.

2. A good therapist makes this process much easier, but it is not the only way; much that has been learned from therapy can be

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applied to education, family life, and the guidance of one's own life.

3. Respecting and understanding the forces of fear, regression, defense, and safety, make it much more possible to help oneself and others to grow toward health. False optimism means disillusionment, anger, hopelessness.
4. Human weakness cannot be understood without understanding its healthy trends, and vice versa. To help others, we must realize not only that they try to actualize themselves, but that they are also reluctant or afraid or unable to do so.
5. It is very important for a man to recognize that every falling away from species-virtue, or every crime against his own nature, records itself in his unconscious and makes him despise himself. If he does something he is ashamed of, it registers to his discredit; if he does something honest or fine or good, it registers to his credit; ultimate result -- he either respects and accepts himself or he despises himself and feels contemptible, worthless, and unlovable.

BASIC ASSUMPTIONS

1. Each man has an essential inner nature which is instinctive, intrinsic, given with an appreciable hereditary determinant, and which tends strongly to persist. This inner nature includes basic needs, capacities, talents, anatomical equipment, natural inclinations. This raw material very quickly starts growing into a self as it meets the world outside and begins to have transactions within it.
2. These potentialities have a life history and a development. They are actualized, shaped, or stifled mostly by outside determinants (culture, family, environment, learning, etc.).
3. This inner core is weak, easily overcome, suppressed, or repressed. In rare cases it may even be killed off permanently by cultural expectations, fear, disapproval. It has impulse-voices, also weak at first, and the ability to hear them contributes to authentic selfhood. There are wide individual differences in the strength of these impulse-voices.
4. Each person's inner nature has some species-wide characteristics and some idiosyncratic characteristics.
5. Many aspects of this inner nature are either actively repressed because they are feared or disapproved, or they may be forgotten through neglect, disuse, etc. Therefore much of the inner nature is unconscious, not only the instincts and needs, but also the capacities, emotions, judgments, attitudes, etc.
6. Even though weak, this inner nature rarely disappears or dies--it persists underground, unconsciously. Energy must be used in its suppression or repression, causing fatigue.
7. As the inner core of self grows into adulthood, it is composed of what is there beforehand and what the person himself creates, since he continually makes choices -- thus he is his own main determinant.
8. If this essential core is frustrated, denied, or suppressed, sickness often results, immediately or later on. The main

source of illness is frustration of the following basic needs: B-values, potentials, self-expression, tendency of the person to grow in his own style at his own pace, especially in his early years.

9. This inner nature is definitely not "evil" -- it is "good" or natural. Since therapy lessens hostility, fear, greed, etc. and increases love, courage, creativeness, kindness, altruism, etc., the latter qualities seem more natural and basic than the former.
10. Evil behavior -- unwarranted hostility, cruelty, destructiveness, aggression is reactive, not basic, because uncovering therapy reduces it and changes its quality into healthy self-affirmation, forcefulness, selective hostility, self-defense, righteous indignation, etc.
11. No psychological health is possible unless the essential core is fundamentally accepted, loved, and respected by others and by the self. (The converse is not necessarily true.)
    a. acceptance and expression of the inner core or self, actualization of latent capacities and potentialities, full-functioning.
    b. minimal presence of ill health, neurosis, psychosis, or loss or diminution of the basic human and personal capacities.
12. Internalized conscience is the introjection of the disapprovals and approvals of others; its accompanying guilt is the recognition of the disapprovals. Besides the internalized conscience, a person has an intrinsic conscience, based on the unconscious and preconscious perception of his own nature, destiny, capacities. It insists that he be true to all of these -- if he doesn't he perceives in some deep way that he has done wrong to himself and he despises himself for it. Intrinsic guilt is the consequence of betrayal of one's own inner nature (a turning off the path to self-actualization) and is essentially justified self-disapproval. Out of this self-punishment may come only neuroses, but there may equally come renewed courage, increased self-respect, because of thereafter doing the right thing -- growth and improvement can come through pain and conflict.
13. The unconscious, regression, and primary process cognition may be unhealthy or dangerous or bad, but can also be good or beautiful or desirable. The roots of love, creativeness, play, humor, art, etc., are deep in the inner self or unconscious, and to recover them and enjoy them, we must be able to regress.
14. Pure spontaneity in society is not possible except in short spells, because of the world and its laws, but it IS possible in dreams, fantasies, love, imagination, sex, the first stages of creativity, free association, etc. Pure control is not permanently permissable, for then the psyche dies. Education must be directed toward cultivation of controls AND spontaneity and expression. In today's culture it is necessary to stress the latter -- we are and have been over-controlled.
15. Most of the time the normal child, if given a really free choice, will choose what is good for his growth -- he knows,

better than anyone else, what is good for him. A permissive regime does not mean that adults gratify his needs directly but make it possible for him to gratify his own needs and make his own choices -- to let him BE. In order for children to grow well, it is necessary that adults have enough trust in them and in the natural processes of growth, not to interfere too much, not to MAKE them grow, or FORCE them into predetermined designs, but rather to let and help them grow.

16. The main path to health and self-fulfillment is via basic need gratification rather than through frustration, suppression, mistrust, control, policing that goes with the belief in basic, instinctive evil in human depths. Self-denial, deliberate rejection of the demands of the organism, tend to produce a diminished, stunted, or crippled organism.
17. Complete absense of frustration is dangerous; to be strong, a person must acquire frustration-tolerance. The child whose needs for safety, love, and respect are gratified can profit from graded frustrations; if they are too much for him, they cause trauma. If they match his tolerance he learns the difference between reality and wishes, learns about his own limitations, and acquires the ability to love others as they may need it. Overprotection means that the child's needs are gratified for him by his parents; he doesn't learn to do this for himself; he remains infantile, doesn't develop. Instead of healthy learning, he learns how to use others rather than to respect them, learns that he isn't trustworthy; it is essentially condescending and insulting, making him feel worthless.
18. To make growth and self-actualization possible, it is necessary to understand that capacities, organs, etc., press to function and express themselves, to be used, and that such is satisfying, and disuse is irritating. Capacities are also needs, and enjoyable when used.
19. Cognition includes perception, learning, remembering, attending and thinking. In D-(deficiency) cognition, the world is organized into gratifiers and frustraters of our own needs, with other characteristics being ignored or slurred. B-(being) cognition is the perception of the object in its own right and its own Being, without reference to its need-gratifying or need-frustrating qualities, its value for the observer or effects upon him. With increasing selfhood, or acceptance of one's own inner nature, B-cognition becomes easier and more frequent. However, D-cognition remains for all human beings the main tool for living in the world.
20. B-love and D-love follow the same rules. No ideally good relation to another human being, especially a child, is possible without B-love, particularly in teaching. The ideal is to treat the natural world in its own right, not as if it were there only for our purposes.
21. Self-actualization rarely happens (less than 1% of the population).
22. Growth has not only rewards and pleasures but also many intrinsic pains. Each step forward is a step into the unfamiliar

and may be dangerous; also we give up something, good, familiar, satisfying; it may mean a parting, kind of death, nostalgia, fear, loneliness; often it means giving up a simpler, easier life in exchange for a more demanding, more responsible, more difficult life. Growth forward is in spite of these losses and therefore requires courage, will, choice, strength, as well as protection, permission, and encouragement from the environment, especially for the child.

23. Growth has both advantages and disadvantages. Ideal way of growing healthily is to enhance the advantages of growth and the disadvantages of not-growing (and vice versa). Defense mechanisms are prepotent over growth-tendencies, are quite necessary, and not always pathological.
24. A neurosis is not part of the inner core but rather a defense against it or an evasion of it, as well as a distorted expression of it due to fear of it. Usually it is a compromise between the effort to seek basic need gratifications in a hidden or disguised or self-defeating way, and the fear of these needs, gratifications, and motivated behaviors. Each neuroticized need or emotion or action is a *loss of capacity* to the person, something that he cannot do or dare not do except in a sly and unsatisfying way. Also he loses his will, feeling of self-control, capacity for pleasure, self-esteem, etc.
25. Absence of a system of values is psychopathological -- the human being needs a framework of values, a philosophy of life, he has a need to understand. Our present external values have been proven to be failures; we need a validated, usable, system of human values to believe in and devote ourselves to, because they are true, rather than because we are told them-- values from the inner self rather than from the environment. Much disturbance in children and adolescents is a consequence of adults -- uncertainty about their values, so they use their own immature confused values.
26. In self-actualizing people, many dichotomies become resolved, opposites become unities, work becomes play; duty becomes also pleasure; the individual fuses with nature; conscious, preconscious, and unconscious integrate; id, ego, superego merge; Freudian instincts and their defenses are less sharply set off against each other.
27. In SA people impulses are more expressed and less controlled; controls are less rigid, inflexible, anxiety-determined; superego less harsh and punishing; primary and secondary cognitive processes more equally available and valued (instead of primary processes labeled pathological); in peak-experiences, they tend to fall together. The unconscious can sometimes be healthy, regression desirable; irrationality may also be considered healthy, desirable or even necessary.

    Their conative, cognitive, affective, and motor functioning are more integrated and collaborate without conflict to the same ends; what he enjoys is apt to be what is good for him; his spontaneous reactions are as capable, efficient and right as if they had been thought out in advance; sensory and motor reactions are more closely correlated, etc.

28. Abstract, verbal, and analytic thinking do not grasp the total reality, preverbal, primary process, intuitive, and esthetic types of cognition are needed for the enriched or total perception. Creativity has its roots in the nonrational; language is inadequate to describe the total reality; and abstract concept leaves out much of reality.

29 Use of the unconscious, preconscious, primary processes(without fear), impulses (without control), regression (without fear), all are the main conditions of creativity.

30. SA does not transcend all human problems; conflict, anxiety, frustration, sadness, hurt, and guilt can all be found in healthy humans. With increased maturity, the movement is from neurotic pseudo-problems to the real, unavoidable, existential problems. Guilt and intrinsic conscience are sometimes necessary. Even though one has transcended the problems of Becoming, there remain the problems of Being.

31. Mature man must learn to give up the child's wish for the exclusive, total love of his parents, while learning to love others. He must learn to gratify his own needs and wishes, rather than the needs of his parents; must learn to gratify them himself rather than depend upon them to do this for him; give up being good out of fear and in order to keep their love, and be good because HE wishes to be; discover his own conscience and give up his internalized parents as his ethical guide; replace fear with courage. All these techniques are necessary for the child, but immature and stunting in the adult.

32. "Adjustment" is NOT synonymous with psychological health -- the question is to what people, environment, or culture is the person adjusting, or how he is being used by them. True health transcends these factors and can be defined by a man's intrapsychic laws, not his ability to master the environment, to be capable, competent, etc. in relation to it. None of these is a major criterion of worth or health of a person.

33. Peak experiences are out of time and out of the world; the rest of the time, people must live in the outer world, in chronological time. The inner psychic world of emotion, wishes, fears, hopes, love, fantasy, art, etc. has its own laws, completely different from the outer world, with its laws made by others. The person who is not afraid of his inner world and enjoys it can cope with the outer world of reality more easily and enjoyably than those who are afraid of their inner worlds.

34. D-need gratifications come from the outside world -- therefore adaptation to this world is necessary; we need to learn to differentiate between the two worlds, to delay gratification, to conceal what would be dangerous, the nature of people and society, the approved and permitted outer world gratifications, and the necessary techniques to achieve them.

35. Not only does the past exist NOW in the person, but so does the future exist NOW for him, in the form of ideals, hopes, duties, plans, goals, unrealized potentials, etc.

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UNIT C : CLIENT MANAGEMENT

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INTRODUCTION TO UNIT C

In Unit C, *Client Management*, the focus is on systemic or programmatic responses that can be made toward prevention of substance dependence. This unit seeks to integrate the philosophical and practical issues that were considered earlier. The goal is to determine which types of programmatic responses help the therapeutic process and which types hamper the efforts of the skilled counselor. Ultimately, the counselor's effectiveness is affected by the programmatic restraints and guidelines under which he or she has to work.

Module 1, Orientation, is designed to re-establish the atmosphere of the training community. An overview of Unit C is presented.

Module 2, Program Diagnosis, is designed to introduce the fundamentals of client management. Each participant identifies the issues involved in client care within the context of a single case.

In *Module 3, The Rehabilitation Process,* the pros and cons of various program procedures are discussed.

In *Module 4, Intake and Assessment,* the screening process through which clients are admitted to a program is examined. A case study assignment gives participants practice in identifying significant intake data.

In *Module 5, Treatment Planning,* treatment planning, including issues such as goal selection, managing clients by objectives, and team approaches to treatment, is considered. The case study initiated in Module 4 is used to give participants practice in designing treatment plans as members of a treatment team.

In *Module 6, Confidentiality and Ethical Considerations,* these two fundamental aspects of the counseling relationship are discussed. The federal regulations are reviewed and the group discusses ethical issues involved in helping an individual restructure his or her life.

Module 7, Community Organization, is designed to present a review of skills and strategies for developing community rapport and cooperation in problem-solving activities. The trend toward developmental activities is explored and negotiation skills are emphasized. Methods for identifying community resources are discussed. Participants will develop an individual action plan for change to be implemented in their own programs.

In *Module 8, Closure,* the training design and the purposes for various training activities are reviewed. The training experience is brought into perspective and brought to a conclusion in this module.

TRAINING GOALS

The Basic Substance Abuse Counselor's Training Program, Unit C, is designed to place client management and program practices into an operational perspective so that the counselor will be able to:

- Distinguish between therapeutic and nontherapeutic processes
- Identify areas of policy and practice that reduce the effectiveness of programs
- Construct more effective therapeutic environments
- Develop appropriate therapeutic goals for clients with the clients' assistance
- Understand methods for implementing program and community change
- Develop an action plan for change in his or her own substance abuse program

TRAINING OBJECTIVES-COMPONENT C

I. Trainees will increase knowledge on addictions and counseling by 30 percent as indicated on pre/post tests.

   A. Given a list of six negotiating elements, trainees will be able to define four of the elements. (Ref: handout and presentation)

   B. Given the seven principles of behaviorial change, the trainees will be able to cite two conflicts between program process and the proper principles.

   C. Concerning clients in the trainee's own program, the trainee will identify an increased number of decision points and an increased number of program personnel involved in the treatment decision-making process after training than before training.

   D. The trainees will be able to list the six steps of community development. (Ref: presentation)

II. Trainees will express a significant positive change (.05 level of statistical significance) in the attitudes below.

   A. Given the statement, "I am willing to discuss procedural problems with my supervisor, or program director, even though there may be a disagreement about the problem," the trainee will express increased willingness to discuss program process.

   B. Given the statement, "A program ought not to cater to differences in client treatment needs," the trainee will express an increased need to deal with client differences.

III. Trainees will meet the following training objectives upon completion of training session (Component C).

   A. Given a case study, the trainees will experience as a group the processes of assessing data, writing a treatment plan, and selecting modes of treatment.

   B. The trainees will be able to develop an action plan for their program or community.

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MODULE 1: ORIENTATION

MODULE 1: ORIENTATION

FOCUS

In Module 1 an overview of Unit C is presented. Unit C is conducted as a seminar, with emphasis on interaction between participants and staff and among participants. This final unit is designed to integrate the perspective built in Unit A and the counselor skills developed in Unit B and to explore ways in which the organization of a program can affect the therapeutic process.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- State the major emphasis of Unit C
- Explain the role of Unit C in the overall course content and flow

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MODULE 1: ORIENTATION

PRETEST

The pretest is given to assess attitudes and knowledge before training. This assessment will help trainers gear the session to the participants' level of knowledge.

ORIENTATION AND OVERVIEW

Unit A (a fundamental facts and insights course that may be delivered in conjunction with Units B and C) focused on the participants' attitudes concerning substance abuse and abuses in relationship to the client's needs; in Unit B participants considered ways in which a counselor can build a therapeutic relationship to help a client meet those needs. This unit is designed to explore the effects that the system delivering the services may have on the counseling situation. The goal of this unit is to provide an understanding of the kind of system necessary for the delivery of successful treatment.

MODULE 2: PROGRAM DIAGNOSIS

MODULE 2: PROGRAM DIAGNOSIS

FOCUS

This diagnostic experience is designed to help each participant understand what happens to a client in his or her program. Participants are asked to identify each point at which a decision is made, who makes the decision, and upon what criteria the decision is based concerning the client; this information becomes the basis for discussion throughout this module and is referred to during the training.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Identify three points in their programs where the staff makes a decision about the client's treatment program
- Explain the criteria on which client-oriented decisions are based
- Identify the decision makers in their programs

MODULE 2: PROGRAM DIAGNOSIS

ACTIVITY: DIAGNOSIS OF PARTICIPANTS' PROGRAMS

Goal

This activity is designed to help a participant understand what happens to a client in his or her program.

Description

In this activity, you will work in small groups, at first independently and then with the group. Work alone to complete your homework assignment: a list of the planned and unplanned steps through which a client might move in your treatment program. Then make a flow chart of this information and mark with a red star the points at which formal or informal decisions are made about the client's treatment.

When all group members have completed their charts, each can share his or hers with the group. While discussing your program, identify what the indicated decisions are, who makes these decisions, and what criteria are used for making the decisions. Consider what actually occurs in your program, not what ideally ought to occur.

Comments

MODULE 3: THE REHABILITATION PROCESS

MODULE 3: THE REHABILITATION PROCESS

FOCUS

The process of rehabilitation is discussed in Module 3. Many errors that are often seen in rehabilitation programs are examined, as are some practices that seem to yield positive results.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Identify three errors commonly made in rehabilitation programs
- Explain the concepts of "middling" and "picking-off" of program staff and explain two ways to avoid these problems
- Identify at least two client management problems that should be considered in staff meetings
- Explain the need for careful organization and monitoring of the intake and assignment processes

MODULE 3: THE REHABILITATION PROCESS

PRESENTATION: THE REHABILITATION PROCESS

This presentation will be in the form of a seminar with participants and trainer presenting ideas and information. It will be based on the resource paper, "The Rehabilitation Process."

SMALL GROUP DISCUSSION

In small groups, discuss the activities in Unit C to this point. Identify and discuss the relevance of ideas presented to possible or actual problems in your programs.

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THE REHABILITATION PROCESS

In Part A of this course we described rehabilitation as the process of helping a client learn, through his or her own practice and experience, the skills necessary to respond with nondependent behavior in situations where he or she formerly responded with dependent behavior (substance abuse). In other words, we are asking programs to assist a client in changing his or her behavior. In Part B of this course we laid out seven steps necessary for behavior change to occur. We noted that problems which arise in the process of behavior change can often be traced to omission or inadequate development of one of the seven steps. Since we are asking rehabilitation programs to be agents of behavior change, looking at our programs in terms of the seven steps for behavior change can help us identify areas where our programs can improve their effectiveness.

Many programs experience difficulty because they fail to establish an explicit, empathetic relationship with their clients (Step #1). A program's ability to be an effective agent for behavior change depends on the client's perception of the program. This perception can make or break a counseling relationship so it is important to become aware of a client's perceptions, attitudes, and feelings about coming to the program. By really putting ourselves in the client's shoes we can begin to build an empathetic relationship.

A client's perception of your program may have been formed long before he enters your door. His perceptions are influenced by the community's awareness and perception of the program and by the process he has gone through in getting to your program. Obviously, a client who has been sent to your program as a term of his probation, or forced into your program by family members will be carrying attitudes and feelings that each staff member must be sensitive to. A more subtle influence on the client's attitude toward the program is the community's perception of the program; however, a staff member can influence the community's perceptions of the program by working with the community to build an explicit relationship with the residents. The amount of community education you do, the publicity the program receives, and the program's community involvement all influence the community's (and therefore the client's) awareness of and feelings toward the program. I am sure we would all feel more comfortable coming to (or being sent to) a program that had made an effort to inform the community about its functions through an active campaign of outreach, community involvement, and community education, than to a program that had made no effort to explain itself to the community with a staff that stayed in the office waiting for clients to come to them. Obviously, the involved program can do much to ease the fear, suspicion, and bewilderment about coming to (or being sent to) the program by educating the community about its activities and by personalizing the program through direct staff contacts in the community.

Once the client arrives at the program we are at a crucial point in the process of building a relationship. We can verbalize concern for the client, but if he is told to have a seat while the secretary types and the counselors chat we won't communicate concern. Similarly, giving the client a form to fill out or an appointment for next week can only damage the relationship. It takes a lot of courage to come to a program and ask for help and it takes a lot of pain to drive a person to a counseling program. Future appointments and intake forms do nothing to deal with that pain and they often frustrate a client to the point of changing his mind about seeking counseling. Everyone working in a program should be trained in crisis intervention and interview techniques. The client came for help now and should be seen now. It may be our only opportunity.

This brings us to the second principle of behavior change, focusing on the pain in the here and now. We must make every effort to treat the client when he first contacts the program (even over the phone). During this initial contact we must make every effort to keep his focus on the pain or discomfort that brought him to the program or got him into trouble. Many of the procedures and red tape required by programs shift the client's focus away from the here and now. Intake interviews, for example, often ask questions about past arrests, past substance involvement, and past treatment experience, or demographic data that has nothing to do with why the client is in the program right now. Moreover, focusing on such an intake procedure may tell the client that we care more about getting our paper work done than we do about him and his problem. If we establish an empathetic relationship and help the client with his problem, he'll usually stick around to give us the demographics.

Step three in the process of behavior change involves opening feedback channels in both directions. It is our responsibility to make certain this component of the change process is present on both a counselor/client and a programmatic level. We must insure open honest feedback to and from clients, other staff members, and the community we are serving. A program that does not give feedback to clients, staff members, and the community isn't living up to its responsibility as an agent of change. A program that doesn't solicit feedback from clients, staff members, and the community it serves becomes a rigid non-communicative system and is heading for trouble. For example, a program that doesn't have a method of receiving feedback from clients will never learn how the program is perceived by clients or how its services could be improved to better serve its clients. A program that has no procedure for giving (community development and education) or receiving (periodic needs assessments, open board meetings) feedback from the community it serves cannot hope to impact (change) the community and is in danger of becoming obsolete as the community changes and the program stays the same. A program that doesn't set up procedures (regular staff meetings, joint treatment planning, regular case review) that promote open communication and honest feedback among all staff members, faces a myriad of potential problems including sabotage of the process of behavior change by clever clients or petty staff disputes. For example, unless staff members meet regularly to discuss client treatment plans, counselors lose creative input from other staff members on their observations of the client and their ideas on how the client can best be served. Moreover, it is important for each staff member to be aware of each client's needs and treatment goals in case the client needs help when his primary therapist is unavailable. In residential programs, clients will often undermine staff members and sabotage program efforts by asking several staff members about a program policy or asking several staff members for a favor. Unless the staff is familiar with the client's treatment plan and has a procedure for dealing with such requests, the client can "pick off" certain staff members and expose a noncommunicative program. A program must establish and commit to writing a set of policies and procedures aimed at opening feedback channels to and from clients, community, and staff.

Step four in the process of behavior change is formulating the problem. Suffice it to say that many substance abuse programs don't really help a client identify the actual problem. Instead, programs often identify every client's problem as a drug problem or an alcohol problem. This is the "one way" approach mentioned in Part A of this course. This approach meets the needs of the program rather than the needs of the client. Unless a program is flexible enough to look beyond the symptom (substance abuse) and help the client discover his real problem the process of behavior change is short-circuited.

Similarly, the program that doesn't help a client discover his real problem usually doesn't help the client explore optional behaviors (Step #5). The program that is quick to identify the client's problem (drugs, alcohol) often has a standard solution (one-to-one counseling, abstinence). The program that is really interested in helping clients find new ways of behaving will encourage clients to explore all possible options and will individualize each client's treatment plan. This doesn't mean that the program must provide every alternative itself. Limiting clients to those alternatives that are available through your program restricts optional behavior. Offering two or three ways isn't much more flexible than offering "one way." Almost any community offers a wealth of alternative activities and the effective program learns as much as possible about each of these alternatives so that the resources of the community are at the program's disposal and can be mobilized to assist in the process of behavior change. Moreover, the effective program encourages each client to explore and select options of his own creation as the client takes greater responsibility for his own behavior change.

Once the client has selected the optional behavior he feels is most appropriate the program must help the client integrate and risk the new behavior (Step #6). The program must provide a nonthreatening learning atmosphere where the client has the opportunity to practice the new behavior so that he will be prepared to risk the new behavior outside the program. Programs that help the client identify the problem, choose the new behavior, and then send him on his way are setting him up for failure. The client will have no safe environment to practice his new behavior unless the program encourages the client to risk the new behavior in the program. If he has trouble risking the new behavior around his counselor, imagine how difficult it will be to try around his family.

Even when the client has had the opportunity to risk the new behavior in a nonthreatening environment, failure is still a possibility. The process of behavior change is not complete until the client has explored this possibility and the other reactions his new behavior may cause. Programs should explore the contingencies (Step #7) with the client and build follow-up procedures into the program that take these contingencies into account.

The rehabilitation process is a process of helping a client substitute nondependent behavior for his substance-dependent behavior. Successful execution of the process requires that all the steps for accomplishing behavior change be present and adequately developed on both the client-counselor and the programmatic level. It is the responsibility of each staff member to make certain that the program lives up to its responsibility to be an agent of change by a careful consideration of the seven steps on the programmatic level.

MODULE 4: INTAKE AND ASSESSMENT

MODULE 4: INTAKE AND ASSESSMENT

FOCUS

The screening process, through which clients are admitted to a program and assigned to a particular counselor or method of treatment, is examined in Module 4. The types of information that must be obtained during this process are identified and assessed.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Identify three items of importance in the intake process
- Demonstrate an operational understanding of the intake process by identifying important intake information contained in a case study
- Name three types of unnecessary information often gathered during the intake process

MODULE 4: INTAKE AND ASSESSMENT

PRESENTATION AND DISCUSSION: THE INTAKE PROCESS

This will be a presentation and discussion on the purpose of the intake process and the types of data necessary to make a proper assessment and develop a treatment plan. Read "Criteria for Selecting Client Intake Data" in preparation for the discussion. *Use the space below for any notes.*

ACTIVITY: CASE STUDY, DATA GATHERING

Goal

This activity is designed to help participants identify pertinent data for client assessment.

Description

Work independently within the small group to identify significant data from the case study. Take as much time as necessary to determine what information is pertinent for treatment planning.

Comments

CRITERIA FOR SELECTING CLIENT INTAKE DATA

by

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CRITERIA FOR SELECTING CLIENT INTAKE DATA

When a client first contacts a helping program, most of us would agree that we in the program should relate to him responsibly. This means being responsible to him and for him as is appropriate.

In the Seven Principles of Building a Client-Counselor Relationship for Behavioral Change, we list (1) establishing empathy with the client and (2) establishing a clear, explicit and shared understanding of why the counselor and client are together and what is expected of each --- as the initial matters of counselor concern.

With regard to establishing empathy, it is not difficult to see how the process of gathering intake data can be, and frequently is, anything but an empathy building process. For reasons not altogether clear, intake interviewers (counselors) put a client through a most unempathic data gathering experience usually because the "program requires that this form be filled out." Suffice it to say that the intake process, in terms of human dynamics, needs to be looked at with a critical eye and with an openness to the possibility of changing it. Intake is all too often a first contact a client has with the therapeutic process, and in terms of process, should not work against this therapy.

On the other hand, gathering intake data can be and should be an important step in establishing a clear, explicit understanding of why the client and the program (counselor) are coming together. The intake interviewer has the responsibility for managing what data is solicited and what data is not solicited. To this end, this paper is offered to provide some guidelines for the intake interviewer.

Counseling in the substance abuse field deals with changing behavior. Different behavior is the sought end result. Depression, poor domestic relations, unemployment, etc., all may be desireable to change --- but it is the client's own personal behavior that we deal with --- not the situations themselves.

If, therefore, we will work with the client to help him change behavior, we have to know (and he does, too) how he is behaving now. What is he doing now that he wants to do differently? Unfortunately, clients frequently don't want to deal with changing their own behavior or even suspect that their own behavior creates the painful "situations" in which they find themselves. They would rather focus on changing others or changing situations. Nevertheless, our job is helping a client change his behavior.

This has a direct relation to gathering data. We want to gather data about how a client is functioning (behaving) now in the significant areas of life. We want to know what he is doing in the areas of his inner-self, his relations with others, and his organization of his life in that little part of the world in which he lives.

I want to bring up at this point another concept with which we dealt --- the concept of the "Whole Person." If we are true to what we have said, we are interested not simply or primarily in our client's substance abuse but what he is doing for himself physically, mentally and spiritually. My point is, then, that our intake questions (management) should reflect this total concern. The questions asked a client at intake all too often reflect a very narrow concern, such as his substance use.

Okay, we have said we (1) want to discover how a client is behaving (functioning) now in the significant areas of life and (2) want to discover how a client is behaving now in the totality of his life --- all parts of him.

What are significant areas? Let's list all those we can in which any whole person might be concerned: It is improbable, perhaps impossible, that all the important data in these areas can be obtained during an intake. Yet it is ultimately important to learn about these areas, and where data does fall out in intakes, it is helpful to assign it to its appropriate area of concern.

I. Physical

    1. Basic demographics: name, age, address, phone, etc. (just enough!)

    2. Health now, including history as it affects the now.

    3. Physical habits now including sleep, work, relaxation, substance abuse, etc.

II. Interpersonal

    1. Family, parents, children including any history that has relevance now.

    2. Significant human relations outside of family.

III. Education/Vocational Skills

    1. What can he do? What does he know?

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2. What is his educational and vocational history that has relevance now?

IV. The Self

1. Does he like himself? How does he describe his self-concept? What are his social imprints, the tapes, the messages he responds to now?

2. What does he do for his emotional and spiritual well-being now?

3. What areas listed above (Physical, Interpersonal, Educational/Vocational) is he dissatisfied with? okay with?

4. What are his intrapersonal skills? self-discipline? personal responsibility? ability to make personal decisions and act on them?

5. What is his presenting problem as he sees it now? What is he doing?

V. Organizing Capacity

1. What does he do to organize his activities? How does he make judgments? assessments? about the situations in which he lives?

2. Does he know how "the system" works? how to get a job? plan and save for future needs? etc.

3. Social-legal history - what have been his contacts with the law, etc.?

One important aspect of gathering data about a client is to distinguish very clearly between (1) fact --- "what happened" and (2) opinion --- the assessment or interpretation of the facts. With regard to (2) opinion, it is also important to distinguish between "whose opinion" --- the interviewer's or the client's. What's terribly important is for the intake interviewer *not* to make interpretations about facts or assumptions of which he himself is unaware. Know that your assumption is just that --- an assumption, not a fact.

Nevertheless, it is the job of the intake interviewer to assess the significance of the "facts," the information and data presented to him by the client. I shall suggest two criteria to use in this respect:

1. Look at the data given about the significant areas of

life (Physical, Interpersonal, Evaluation/Vocational Skills and Organizing Capacity) from the point of view of Habilitation Skills (sometimes referred to as Survival Skills!). Remember, Habilitation Skills are three: (1) Intrapersonal (decision-making, personal responsibility, personal goals, personal assessment) (2) Interpersonal (communication, listening, capacity for empathy, ability to give and receive love) (3) Organizational (capacity for judging and assessing situations in which he lives, planning and forecasting).

Look, then, at the data you receive about your client --- himself, his family, his job, his education, his health, his substance use, etc., and ask yourself: "Which of the Habilitation Skills does this data speak to?" Does what he tells you point toward Intrapersonal, Interpersonal or Organizational Skills? Does his drinking, his family, social, legal and vocational history point to poor interpersonal skills? organizational skills? When, through your assessment of the data, your suspicion that one of his survival skills is limited, you may wish to go back over the significant data areas again looking at them with this particular habilitation skill in mind.

2. Cluster all the data you can assemble in terms of the particular survival skill. By clustering drinking behavior data, for example, with other data (marital, physical, legal, etc.), it may be quite evident to you that he needs to be trained in, say, Intrapersonal Skills. You then will have some clue as to the appropriate form of treatment plan you will recommend, which is the main reason for intake data gathering in the first place.

To say what has been said again by way of summary:

1. Evaluate the intake questions and procedure in terms of empathic relationship building.

2. Look at intake data gathering in terms of establishing explicitly "why you and the client are together --- what you expect from each other."

3. Substance abuse counseling has the goal of client behavior change. Therefore, the data gathered about a client should be behavioral.

4. We believe in the "Whole Person" concept and the data gathered should be related to all significant areas of a client's life.

5. Distinguish between "data" and "opinion." What are the facts?

6. Determine whose opinion. Yours? Your client's? His wife's?

7. Give significance to data collected in terms of the client's habilitation skills.

8. Cluster, assemble the data under one or more of the three habilitation (survival) skills.

9. Having determined the particular habilitation skill that is deficient, your treatment plan may be designed appropriately.

CASE HISTORY

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CASE HISTORY

INFORMATION FROM PRESENTENCE INVESTIGATION

On 4-13-72, client was stopped at 1:30 a.m. after being observed to be driving in a reckless manner. He was subsequently given a BAC test and scored .24%. Client stated that he had stopped for a few drinks after working an extra long day and was going to stop at a restaurant for coffee and a sandwich before going home. He was not sure why he was stopped by the police.

Client was born in Cleveland 31 years ago and was brought to Indianapolis when only a few months of age. His parents were divorced when he was six and he saw very little of his father from then on. His father remarried and fostered a home in Michigan but the client and his brother were raised by his mother and maternal aunt.

Client quit high school and joined the Navy at age eighteen. He was in the Navy from 1958 to 1962 and received an honorable discharge. He received his G.E.D. certificate while in the Navy and when discharged he attended Los Angeles City College for two years.

Client married present wife in 1968 in Walton, Indiana. Neither had been married before. They have an infant son.

Client currently works at the Carpet Center as a salesman and has been with them since summer, 1972. He earns about $250.00 gross weekly but works every day of the week. He maintains that he has several sizable debts and that his earnings dropped considerably last year. Because of his earnings in the present job, he expects his financial situation to improve.

He is a sports enthusiast and enjoys local college and professional basketball. He played football in college and high school and follows this sport rather carefully. He states that his son gives him much pleasure and motive for staying around home. He has always enjoyed good health.

He is Protestant but does not attend church services.

Regarding his arrest, he realized police have a duty as well as he as a citizen, but since settling down when he got married, he expected no incidents such as this to happen. He seems to be serious and sincere in his attitude toward his wife and family, and proud that he has a job that enables him to care for them accordingly.

At the time of his arrest, his BAC test revealed .24% and later when given the Michigan Highway Safety Test, he scored 44. Although he has had a couple of scrapes with the law, he had only one prior OMVUIL charge and that was in California seven years ago.

Client was put on probation and attended DWI school. On the Johns Hopkins Test and "Who Has A Problem?" questionnaire, he answered affirmatively to only two questions, revealing that drinking makes him irritable and that he is embarrassed by things he says and does when drunk. In DWI school, he indicated interest in receiving further counseling and was scheduled for an appointment with the ASAP Health Countermeasures counselor, on 12/14/72.

INFORMATION RECEIVED FROM FIRST INTERVIEW

Client arrived promptly. He was well-dressed and well-mannered. He gives the appearance of a high school football hero. He wants us to determine if he has a drinking problem. During the discussion of the drinking habits, etc., he finally admitted he is desirous of assistance with a 26-year-old wife who has become quite obese and does not want to work, but is becoming quite uneasy with the "four walls" at home. There is an eleven-month-old baby that keeps him from leaving. He is completely "turned off" by her sexually, primarily due to the weight. He indicates that he is both mentally and physically exhausted. He feels he should never had married, but felt family pressure to do so when he was in some legal trouble and it was believed that being married might prevent him from going to prison. (He was found guilty four years ago of intent to commit a felony-burglary, but placed on probation.)

Client does admit to drinking and indicates he was really "loaded" the night he was arrested. He related that such extensive drinking may occur as many as three times a year. He usually drinks beer. If he is alone and stops for a drink he'll have one or two beers, but if he is with someone or knows someone in the bar he may have several. The wife usually consumes no more than ten drinks a year.

They seldom drink at home. Client indicates that he drank heavily while in service, every night, extensively. Beer was consumed until the money ran out.

He was busted in California for operating under the influence He hit a car. The incident cost him $2500 total. At that time he was living with a woman in California and they had engaged in a severe fight before this drinking episode.

He relates he is embarrassed to take his wife any place because of her appearance. He has threatened to leave and even struck her. Neither has encountered any professional counseling, but he feels it is worth the effort to get somebody who will try to help them both. He believes that the drinking is not the prominent problem at the present, but indicated he is fearful he may do more of it if the home situation is not alleviated somewhat.

Prior to his present employment which involves many and varied hours or work, he was self-employed. He considers himself a hustler, and from all indications has been exposed to and acquainted with many of the "pros." This includes gambling, and sales of various types.

INFORMATION FROM HOME VISIT

Family rents a well-kept, two-bedroom aluminum-sided home, which is comfortably furnished in relatively new furniture. Wife was cordial and the conversation was easy-going. Counselor explained program and asked why client had been interested in receiving counseling. Her reply was that he was interested in finding out what his problems were and how to solve them.

With a bit of encouragement and side conversation, the wife related the following information:
At the age of 6, his parents separated and soon after, his father died. He was raised, along with a brother, who is 8 years older than he, by his mother and aunt. After he got out of college, he started working as a salesman, which is his trade.

They were married 6 years ago. The first year of marriage was hard because client was not used to thinking about someone else, i.e., in not calling to tell her he would be home very late, etc. It was also then that his drinking was heavy and he spent night out with the guys.

They moved to Ohio on a different job at which point his drinking lessened a great deal. They then moved to Indianapolis.

In the last 6 years, he has started drinking heavily twice — the first year of their marriage and a few years ago. Her reaction to this was one of madness at the much-needed money that was being spent and fear for his well-being and her peace of mind. The second time, he went on a week's binge and then cried and asked for her to help him. She agreed to help him and said she would also try to get some outside help for him — but never did because they couldn't afford a psychiatrist. She said his drinking slowed down a great deal after that and has never gotten as great as before.

Now, when he drinks, he follows the blood-alcohol chart he received in DWI school and has gotten his friends to do the same. Now, when he comes home late from drinking, he blames her for things, i.e., her weight. He brings her weight up seldom when he has not been drinking. Although she has been just as heavy for the last 2-3 years, he has brought it up in the past year only. She is currently on a self-imposed diet. (In counselor's opinion, she is about 40 to 50 pounds over-weight) When they have sex after he has been drinking, he can't get physically excited sometimes and blames this on her weight. In relation to work, he has held no job over one year, usually quitting because of a "get rich scheme" or dissatisfaction with the job. In spite of his short work periods, he never has trouble getting another job. He is earning more now than he ever has and works 7 days a week on commission. Although this is usually a slow time of the year for sales, he is busier than ever. The wife worked before her pregnancy. It was during that time that the client quit his job and was slow in finding another one. She feels that if she starts working again, he will let her have all the financial burdens again. She enjoys staying at home, but regrets not having a driver's license to run the errands. She has never learned to drive and client does not have time to teach her. She doesn't feel they can afford private lessons.

Client has previously been involved in a burglary charge before they were married, about which the wife knows little, and a federal offense involving transporting pornographic films across the state lines to sell them. On the last offense, he still has one year's probation left (out of three). He will be able to get his driver's license in a few days, but has one more month of probation left for the OMVUIL offense.

MODULE 5: TREATMENT PLANNING

FOCUS

The importance of an individualized treatment plan and the methods by which one may be developed are considered in Module 5. Participants will develop treatment planning criteria and will work in teams to design a treatment plan.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Identify three modes of treatment and explain the criteria for placing a client into that mode
- State two advantages of treatment teams
- Explain the advantages of negotiating a treatment plan with a client
- State two reasons why programs must be flexible in their expectations of clients

MODULE 5: TREATMENT PLANNING

PRESENTATION: TREATMENT PLANNING

This presentation will highlight the major aspects of treatment plan development. (See "Management of Client Behavior Change.") *Use the space below for any notes.*

ACTIVITY: TREATMENT PLANNING

Goal

This activity is designed to help participants understand how to use assessment data to develop a treatment plan for a client.

Description

In the small group, report individually on the results of the data gathering activity conducted in Module 4. State which data you considered significant and give reasons for your choice. As a group, compile a list of significant data and write these on newsprint.

Then use this assessment data to develop a treatment plan for the client. There are no programmatic limitations within which you must work; attempt to devise an "ideal" treatment plan. Be prepared to justify each step in the plan.

Comments

DISCUSSION

Each small group will report its treatment plan to the training community, noting the rationale used to make treatment decisions. For example: *The client was placed in group therapy because persons with characteristic X profit from this treatment and the client has characteristic X. We determined this from fact Y in the intake information.*

At the conclusion of the reports, the large group should discuss issues such as the role of the group in devising the treatment plan, the validity of the rationale used, and personal responses to the process.

MANAGEMENT OF CLIENT BEHAVIOR CHANGE

by

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MANAGEMENT OF CLIENT BEHAVIOR CHANGE

Helping people change their behavior has generally been viewed with skepticism in our culture. Periodic debate is heard in our government, colleges, and communities concerning whether we should lock people up, execute them, or rehabilitate them. Regardless of who won the individual debate, our nation has created a vast array of institutions to help people change their behavior which is either unacceptable to the individual or to society or to both. We have reform schools, prisons, rehabilitation centers, schools, job training programs, behavior modification centers, methadone clinics, The Salvation Army, Boys' Clubs, Rescue Missions, Alcohol Recovery Centers, Drug Abuse Centers, Weight Watchers, and Alcohol Anonymous.

The public, while continuing to support such programs, experiences the same problems in their communities: crime in the streets, drug trafficking, drunk driving, child abuse, unemployment, and suicide attempts. Although success rates vary from program to program, most can boast of only minimal achievement for their clients if meaningful and permanent behavior change is seen as their goal. How is it that we can send people to the moon and can't seem to help the majority of the 10-12 million alcoholics in this country? We could blame it on lack of money, society, or the alcoholic himself, and perhaps rightfully so. However, in terms of our roles as counselors, to do so often affords each of us a cop-out from critically and analytically assessing how we can improve the quality control of our product (behavior change).

In focusing on how we can improve the quality of our product, we need to examine the machine which produces our product: ourselves. There are two primary skill areas in which counselors need competency. One is the delivery of face-to-face counseling services. Most of us have devoted some time to the understanding and development of such face-to-face skills. Many of us have attended a myriad of workshops including interviewing, self-awareness, encounter, communication skills, and empathy development. In fact, many of us actually "get our kicks" from and enjoy the face-to-face aspect of counseling. However, we often overlook the second or "other" skill area necessary for facilitating client behavior change, that of managing the total change process.

Management of the change process of our clients is no easy task. It requires tremendous self-discipline as well as a thorough knowledge of each client, of program and community resources, and of how clients change their behavior. It involves managing our clients' movement from intake, through treatment or (re)habilitation, to aftercare. In the momentary intensity of counseling situations, we often get lost "in the here and now" and forget our management function as a counselor. In this paper I will explore the management function of a counselor, focus on the issues which are integral to sound client management and examine the procedure for managing a client's growth.

Our role as a manager of a client's growth process gives us the responsibility not for our clients' actions but for guiding our clients along a path where they consider the roadblocks of their dilemma, make their own behavioral decisions, and take responsibility for carrying out those decisions. We are responsible for making sure our client has identified what it is about himself that causes him to lose every job he gets, has explored all the behavioral options he has to resolve his problem of being fired, and has developed an action plan of what he can do to keep his present job. We are responsible for moving our client through such a process and must be invested in each client's process but not his behavior. To invest ourselves in his behavior assumes that the client is not responsible for himself and leads only to frustrations for both ourselves and our client.

An important factor which is crucial to the success of client management is the client's investment in his own change process. Management (Blake-Mouton, MacGregor) says that for maximum results or goal attainment a manager should allow the employee (client) to do work which the employee has determined to be meaningful (by involvement in the planning process) and has responsibility for. Thus, a client, who determines his own problem, chooses his own behavior to solve the problem, and takes responsibility for that behavior, will increase the probability of achieving his goal.

In guiding a client's process, another factor which many times "makes or breaks" a client is the amount of stress which we allow the change process to place upon the client. A body-building instructor knows that a weight lifter who can lift only 150 pounds today cannot realistically lift 300 pounds tomorrow. The instructor will devise a step-by-step approach to gradually increase the weight capacity of the lifter from 150 to 300 pounds. Such a process may take months or even years. The instructor knows the key to reaching a goal is to introduce his lifter to gradually increasing amounts of stress. To move from 150 pounds to 300 pounds in one step would insure failure and perhaps permanently damage the lifter. Our role as managers of growth processes requires us to introduce enough stress to allow our clients to grow as quickly as possible but not to the point of dooming them to failure. Poorly managed stress inducement many times results in reinforcement of an already negative self-concept.

Many systems have been developed for client management in the helping professions. These systems vary in degree of complexity and level of sophistication. Which is the best? It varies with programmatic needs. I would urge each of you to use whatever

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system best fits your own management needs. A multitude of variables is instrumental in determining what system would best fit your program. Often external relationships with funding sources, program licensure agencies, accreditation bodies, referral sources, or supportive services will require certain types of management systems. Internal program variables may include number of clients served, type of program, size and skill of staff members, reporting requirements of your agency, and evaluation/statistical needs of your program. No matter what your program variables are and what management system your program develops or adopts, there are five functions common to all management systems. The five functions are:

(1) data collection and assessment
(2) development of treatment or growth plans which include
  a. long-term goals
  b. short-term goals
  c. strategy for accomplishing the goals
(3) periodic review of client progress in attaining goals
(4) termination
(5) aftercare

Different terminology or labels may be used for the five functions but the function is the same. These five functions are consistent with federal and state requirements for programs. The functions are sequential with each function needing completion before proceding to the next.

DATA COLLECTION AND ASSESSMENT

The data collection and assessment function is described in "Criteria For Selecting Client Intake Data" (Salisbury, 1976). It is important to note that no matter how intensive and thorough data collection may be, the assessment function should not be considered complete until the data is grouped according to the corresponding skill area, i.e., intrapersonal, interpersonal, or situational. The skill areas for each client should then be assessed in terms of what skill areas are satisfactory and which are deficient.

DEVELOPMENT OF TREATMENT OR GROWTH PLANS

After the assessment function is complete, we can then begin to develop growth plans for each client. We should keep in mind that a considerable amount of time (possibly a month) may be required for data collection and assessment. Realistic growth plans cannot be developed from a one-hour intake session. If we approach counseling from a wholistic perspective and understand the importance of establishing an empathic and explicit relationship with the client, then the probability that data assessment will serve as a firm foundation for our treatment planning is greatly enhanced.

It may be often necessary to satisfy immediate needs of the client such as medical care, food, or housing before data assessment can be completed. "Get the client out of the weather before you build his mansion."

In addition to the three habilitation skill areas, we should review the other four characteristics of dependent people as we are developing a growth plan with our client. Of these four characteristics, three relate directly to the process of growth planning. Faith in miracle solutions to problems can be replaced by faith in problem-solving processes. If the client is involved in the development of his own problem-solving process (growth planning) and experiences some level of success with such a process, then he will develop faith in it. We are also teaching a client how to take responsibility for his family processes by giving him responsibility in his own growth process. The client will also develop judgemental skills and be better able to recognize, understand, and apply relationships if he is prodded to do so while in counseling.

The fourth characteristic of a dependent person, which we should consider in developing a growth plan, is "Does our client have viable role models?" Are there any persons presently in our client's life from whom he can learn positive life skills by modeling their behavior? If not, we should strongly consider including the development of such relationships in the client's growth plan.

Long-term and short-term growth goals should be developed in accordance with the client's dependency characteristics and skill needs. The growth goals should exhibit two characteristics:

(1) The goals should specify what the client will do, by when, and under which conditions.
(2) They should be measurable and observable both by the client and the counselor.

For each long-term goal developed, there should be accompanying short-term goals whose achievement leads to the achievement of the long-term goal. For every short-term goal there should be corresponding strategy which leads to its attainment. Figures 1 and 2 illustrate the flow and the building process for the development of growth plans and for the accomplishment of growth plans, respectively.

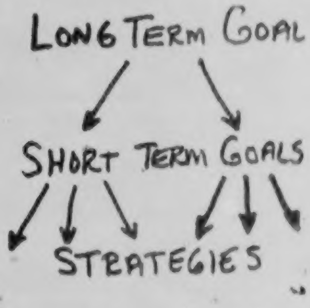

Figure 1. Development of Growth Plan

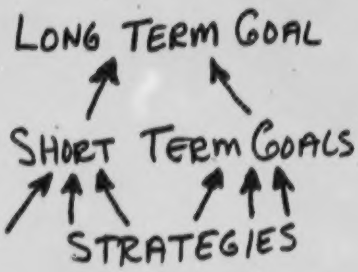

Figure 2. Accomplishment of Growth Plan

In the development of adequate treatment goals, we must take into account the client's self-concept and perception of her situation. Asking a client to contract for behavior inconsistent with her self-concept is building failure into the growth plan. If a client views herself as a junkie and has values consistent with the junkie subculture, it will be nearly impossible for her to achieve growth goals which assume she has values and desires behavior which are consistent with "square" society. The client's position in the life cycle of addiction should be determined before goals can be developed (see "A Conceptual Model of the Life Cycle of Addiction" by Brill, Alksne, and Liebemen).

With a client's self-concept and her dependency characteristics critically assessed, goals and strategy should be developed which the client can actually accomplish. Often we forget that the client with whom we work out goals and strategy for getting herself a job does not have "it together" enough to get out of bed in the morning. The goals and, especially, the strategy should reflect precisely how much stress or change a client can handle without failure.

REVIEW OF CLIENT PROGRESS

Once we have developed goals and strategy for our client, there should be a periodic review of a client's progress in attaining his goals. This is best done in a team setting. Every staff member who delivers direct services to the client should be a part of the team as should be the person in charge of clinical services, of other services, and of other counselors. We, as the manager of our client's process, should be in charge of such a team case review and should elicit feedback from the rest of the team. Such a team review can serve three purposes:

(1) We may receive information or ideas from our fellow team members which will give us additional insight into our client's progress or lack of progress.
(2) We may have our perceptions of our client's progress validated and become more confident as managers of a growth process.
(3) It can improve continuity of services delivered by the program and prevent "picking off" of staff members by manipulative clients.

After receiving input from team members, a decision should be made as to whether client progress is satisfactory and whether or not the goals and strategy should be revised. If revision is necessary, the client should be included in the process.

TERMINATION

The process of ending a relationship requires as much energy as building a relationship. As a manager of a client's growth, it is critical that we are aware of the importance of the termination process. Clients and counselors often become dependent on each other. The client has frequently shifted her dependency from substance to counselor. As the client nears attainment of her goals, the growth plan should include a "weening" from the counselor and a taking of responsibility for management of her own growth process. Hopefully, she should have developed the skills necessary for her self-management during the growth process.

If goals were specific, measurable, and observable, it should be easy to determine when to terminate a client. If we and the client know what it was that she wanted to achieve and why she wanted to achieve such a goal, the criteria for successful termination would be cut and dry.

Included in every termination should be a final review of the client's growth process while in the program. This insures the permanence of behavior change by conceptualizing what the client has already felt and done.

AFTERCARE

National statistics concerning substance abuse programs show that the point at which most clients loose control of their substance usage occurs shortly after they are terminated from a program. This implies that we as counselors must place greater importance upon aftercare planning for the client. If the client has developed the skills during treatment which are necessary for managing her life, she should be able to develop an aftercare plan for herself which considers all the contingencies of re-entry into community life. We should be responsible for making sure that every client has developed such a plan which both the client and ourselves view as realistic.

Included in the plan should be scheduled contact between client and program. It is important that the client understand that she has the option of returning to the program for support if she deems it necessary. She should also feel that she will be accepted by the counselor and the program if she does return for support.

It is imperative at the conclusion of a client's involvement with a program that the client has come to view change as a process and not an event. Having control over substance usage is not something that occurs overnight but it is a skill-building process. Clients who understand this at the termination of treatment have a much greater probability for gaining control over their behavior.

MODULE 6: CONFIDENTIALITY AND ETHICAL CONSIDERATIONS

FOCUS

In this module, two fundamental aspects of the counseling relationship -- confidentiality and the ethical considerations -- are discussed. The federal regulations are reviewed and the group discusses ethical issues involved in helping an individual restructure his or her life.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Outline the major aspects of the federal regulations in the confidentiality of alcohol and drug abuse patient records
- State three ethical considerations for substance abuse counselors

MODULE 6: CONFIDENTIALITY AND ETHICAL CONSIDERATIONS

PRESENTATION: CONFIDENTIALITY

There will be a presentation about confidentiality of client records, followed by a question and answer period.(See "Confidentiality" and the *Federal Register*.) *Use the space below for any notes.*

ACTIVITY: ETHICAL CONSIDERATIONS

Goal

This activity is designed to help participants understand how confidentiality and ethical considerations can affect the counseling relationship.

Description

In small groups, identify, analyze, and generalize about confidentiality of client records. Then, with the assistance of a facilitator, discuss ethical considerations that can affect the client-counselor relationship. Some areas that can be examined are: (1) the role of control and coercion in counseling; (2) the consequences of sexual involvement; (3) the use of positive and negative manipulation techniques and the difference between the two; (4) the setting of behavioral standards for others.

Comments

CONFIDENTIALITY

From NDAC, *Assessment Interviewing for Treatment Planning--Training Manual.* Rosslyn, VA: National Drug Abuse Center for Training and Resource Development, 1976.

CONFIDENTIALITY

It has always been one of the counselor's major responsibilities to develop a relationship with the client that is conducive to self-disclosure and to assure the client that that information will be held in the strictest confidence.

The establishment of a trusting counselor-client relationship is appropriately discussed in the sections concerning the development of interviewing skills. There are, however, sensitive areas that are best covered here. A clear understanding of these areas will offer you insight into the nature of your work, help you develop more realistic expectations, and provide a reference point to measure progress. The information that you need from a client may be psychologically sensitive (certain issues may be painful to face or discuss); it may also create personal dangers due to the possibility of reprisals in the streets or of prosecution by the courts.

A client is sometimes reluctant to divulge personal information because he fears disclosure or a breach of confidentiality. Such fears are easily understandable, but must be allayed if treatment is to be effective. The client should be aware that firm regulations exist to protect both clients and professionals. A mark of a good counselor is the ability to develop a trusting relationship in spite of these constraints.

The type of information generated and recorded by drug abuse treatment programs is frequently of a confidential nature; therefore, the potential exists for violating a client's rights to confidentiality. Counselors learn a great deal about a client's personal life during the treatment process. Developing case histories and treatment plans on the basis of the Assessment Interviewing Guide increases the potential for violating confidentiality, since a good case history contains a great deal of information of a personal and highly sensitive nature. The use of case histories and treatment plans implies that such information will be entered in written form. Because of this, it is important that the client understand how this information is legally protected and how the treatment facility ensures this protection.

Current rules and regulations, *Confidentiality of Alcohol and Drug Abuse Patient Records, General Provisions* (**Federal Register**, Vol. 40, No. 127, July 1, 1975), provide you with legal support for dealing with the client's misgivings.

Your responsibilities with regard to the client's records lie in two areas: (1) the use, storage, and security of written records, and (2) the protection of information from illegal (and/or unethical) oral disclosure. Responsibility in the first area is straightforward: you must be accountable to the staff person charged with maintaining and securing client records. The project must have a storage and acquisition system that satisfies Federal laws and regulations. Since many project components will use the clients' records (counseling for treatment, other components for cost analysis, billing, job training), a well organized and well run recordkeeping system is essential. You, as one of many who records and utilizes information, must observe project policies and procedures in keeping records.

The second area of responsibility is perhaps not so easy to fulfill; seemingly inconsequential conversations could result in the unintentional but nevertheless illegal disclosure of confidential information. A client may only be discussed during actual treatment consultation and then only with appropriate staff persons. While the confidentiality regulations are very explicit and quite strict on the subject of oral disclosures, you are also bound by your own moral code and professional standards of conduct (such as those developed by the American Psychological Association or other professional organizations in human services). In essence, *professional standards require that you act on behalf of the client and behave in the client's best interest.*

The Federal regulations apply to all records of identity, diagnosis, prognosis, or treatment and "include any information, whether recorded or not, relating to a patient . . ." (p. 27805 [11]).* Such information includes facts pertaining to attendance, physical whereabouts, and to the client's status. In general, the best policy is to simply decline any discussion about a client unless proper written authorization is obtained.

Since the project director is legally responsible for the project, it is not necessary for a counselor to respond to any request for disclosure of patient records or information; this includes subpoenaed information or information sought by coercive means. If a director orders you to provide information, either written or oral, it is certainly to your advantage to have the order put in writing.

The client's permission to divulge information must be in the form of a *written* consent in all except extraordinary circumstances, such as medical emergencies or by specific court order. Even in cases where information may be obtained without written consent, there are strict regulations governing the nature and extent of the disclosure. To protect oneself and the client, the best policy is to obtain a written release. Once such consent is obtained, however, it should be turned over to the records manager whose duty it is to maintain such releases as part of the client's records.

Information is occasionally sought through secret or covert means. Those seeking the information may be law enforcement officials, creditors, or persons with extra-legal intent. In general, confidentiality regulations prohibit the use of undercover agents and informants in drug abuse programs, or the disclosure of information to such individuals. It goes without saying that disclosures not associated with law enforcement agencies are equally prohibited by and subject to the regulations.

In summary, confidentiality means two things for you: developing a relationship of confidence with the client, and maintaining records with such professional decorum that nothing, either spoken or written, is handled in such a manner that would violate that confidence (or the law).

A synopsis of the confidentiality regulations, which were set forth as part of the Drug Abuse Office and Treatment Act of 1972 and further amended in July of 1975, is presented on the following pages. The reader is warned not to consider himself an expert when he completes this section. On the contrary, any questions concerning these regulations should be handled by a lawyer. It is our intention here to give you sufficient information to know that a lawyer should be consulted.

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*Department of Health, Education and Welfare, and Special Action Office for Drug Abuse Prevention. Confidentiality of Alcohol and Drug Abuse Patient Records. **Federal Register.** Friday, July 1, 1975, 40 (127).

CONFIDENTIALITY OF DRUG ABUSE PATIENT RECORDS

In the area of drug abuse, most records of treatment are entitled to strict confidentiality and nondisclosure. Under 21 U.S.C. 1175, Section 408, of the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), records of the "identity, diagnosis, prognosis, or treatment of any patient" in relationship to drug abuse treatment in hospitals receiving *any* type of Federal assistance must be kept confidential unless specific exemption of the act allows disclosure.

In its legislative report on the 1972 Drug Abuse Act, Congress states:

> Every person having control over or access to patients' records must understand that disclosure is permitted only under the circumstances and conditions set forth in this section (21 U.S.C. 1175). Records are not to be made available to investigators for purpose of law enforcement or for any other private or public purpose or in any manner not specified in this section.

Recently, the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention (SAODAP) promulgated new detailed regulations interpreting the extent of this mandate for confidentiality of patient records. In the preamble to these regulations, HEW and SAODAP reiterated Congress' view that disclosure of patient records was to be limited so as to diminish any impediments to voluntary treatment for drug abuse. A copy of the Special Action Office regulations may be found in Appendices; it should be consulted for information regarding specific situations. Some highlights of these regulations are:

- Appropriate precautions must be taken to provide security for patients' files dealing with drug abuse treatment. Records shall be kept in a secure room, locked file or similar container. Written procedures should be in effect to regulate and control access to such files.
- These regulations apply to any given individual over any period of time, irrespective of commencement date, provided the treatment did not end before March 21, 1972, in the case of drug abuse, and before May 14, 1974, in the case of alcohol abuse. The records of a person whose application is rejected or withdrawn are fully as much covered as those of active patients.
- Any disclosure should be limited to the extent required to serve a lawful purpose or bona fide cause (e.g., medical emergency). In essence, this means that the only information that should be released is that which is necessary to bring about the successful conclusion of the purpose for which the information is being released. Hence, blanket disclosures of all records should be discouraged; only records pertinent to the cause for disclosure should be released.
- The prohibition upon unauthorized disclosure applies whether or not the person seeking the disclosure already has the information, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other basis for disclosure not expressly authorized in the regulations.
- Such prohibition covers all information including attendance, the patient's status in the program, and physical whereabouts of the patient. The disclosure of negative information (e.g., whether an individual is not or has not been attending a program) is equally prohibited.

Disclosure with the Patient's Written Consent

The Drug Abuse Office and Treatment Act does allow disclosure with the patient's *written* consent. A patient's record, identity, diagnosis, prognosis and details of treatment should not be divulged to any Federal, state or local authorities (except for purposes of research, audit, and/or evaluation) without such consent. For example, a telephone call alerting the police to the drug abuse would violate this regulation and thereby violate the law.

The patient's written consent is required in any of the following situations:

- For any disclosure of treatment information to parole or probation officials and/or court officials (If, however, participation in treatment is a condition of pretrial or posttrial release, the patient may consent to unrestricted communication between the program and the court and probation and parole officials.)
- For any disclosure of information to the patient's attorney
- For disclosures to medical personnel or to treatment or rehabilitation programs
- For disclosures to third party payers and funding sources
- For disclosures to family or individuals with whom the patient has a responsible personal relationship
- For any disclosure to employers and employment agencies (In the case of information to a prospective employer, the following conditions must be met: (1) The patient must submit a *written* and *signed* request that identifies the prospective employer. (2) The person supplying the information must verify the request with the prospective employer. (3) The information supplied must be limited to the extent that it meets (but does not exceed) requirements of the purpose for which it is being furnished. (4) No information shall be furnished unless there is credible belief that the information is to be used for the drug abuser's rehabilitation.)

In any situation not otherwise specifically provided for in these regulations, where written consent is given in accordance with the regulations, disclosure may be made for the benefit of the patient if all of the following criteria are met: (1) There must be nothing in the written consent or the circumstances surrounding it to indicate that the consent was not given freely and without coercion. (2) Such disclosure must not cause harm to the patient. (3) Such disclosure should not be injurious to the program-client relationship. The program director has final responsibility in determining if these criteria have been met and whether disclosure should be made,

Circumstances considered to be beneficial to a patient include, but are not limited to, those in which the disclosure may be of assistance to the patient or his immediate family. Examples include welfare, Medicare, unemployment, workmen's compensation, insurance benefits, pension or retirement benefits, and issues pertaining to the patient's interests in any civil, administrative, or other legal proceeding.

In a form for consent to disclosure, the following eight items are required:

- The name of the patient about whom information is being disclosed
- The name of the program making the disclosure
- The name(s) of the person(s) to whom the information is to be disclosed
- A written and dated release for the disclosure of the information
- The signature of the patient or other authorized party granting permission to release information

  (General releases, signed prior to specific requests for information, for example, the type of release required prior to receiving treatment, are not acceptable.)
- A statement of the purpose and need for disclosure
- A description of the extent and nature of the information to be disclosed
- A statement that the consent may be revoked at any time by the patient and a specification of the date, event, or condition upon which it will expire without expressed revocation

  (Any redisclosure normally requires the further specific consent of the patient, and is subject to the same restrictions governing the original disclosure.)

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Consent with Respect to Minors and Incompetent or Deceased Patients

Consent must be given by both the minor and his parent, guardian, or other legally authorized person; any disclosure made after the patient has ceased to be a minor may be consented to only by the patient. In states where treatment is authorized without parental consent, any consent required for disclosure may be given only by the patient.

In a situation where a state requires parental consent and a minor applies for treatment on his own behalf, the fact of such application may not be disclosed to his parents or guardians without his consent. If the applicant refuses such consent, it must be pointed out that he cannot receive services without it.

In states where parental consent is not required for treatment, no inquiry may be made regarding the financial status of the patient's family, nor may any bills or requests for payment be sent, directly or indirectly, to the patient's family or guardians without the written consent of the patient. Such consent may not be made a condition for receipt of services except in the case of a program that is not required by law to furnish services irrespective of ability to pay and does not in fact hold out itself as willing to furnish such services.

If a minor lacks the rational capacity to give consent (either due to extreme youth or mental or physical incapacitation), disclosures may be made to parents or guardians in situations that pose considerable danger to the patient or applicant. The law states:

> When, in the judgment of a program director a minor applicant for services, because of extreme youth or mental or physical condition, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, and the situation of the applicant poses a substantial threat to the life or physical well being of the applicant or any other individual, and such threat might be reduced by communicating the relevant facts to a parent or guardian of the applicant, such facts may be so communicated by the program director or by program personnel authorized by the director to do so. (Section 2.15f)

In the case of incompetents other than minors, consent may be given by legal guardians. The law states:

> Where consent is required for any disclosure (for incompetent patients other than minors) . . . such consent in the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs may be given by the guardian or other person authorized under State law to act in the patient's behalf. (Section 2.16a)

Consent for disclosure of information pertaining to deceased persons may be given by an executor, administrator, or other personal representative. In the absence of such representatives, consent may be given by the spouse or, if none, by any responsible member of the patient's family. Any disclosures required by Federal or state law pertaining to death or other vital statistics may be made without consent.

Disclosure to Third Party Payers

A third party payer is defined as any organization or acting agent that pays or agrees to pay for diagnosis or treatment where such payment is on the basis of an individual relationship between the payer and the client or a member of the client's family (in the case of insurance coverage) as set forth by a contract, insurance policy, or similar documents.

Disclosures may be made to third party payers and funding sources only with the written consent of the patient; only information that is necessary for the fulfillment of legal or contractual obligations on the part of such parties may be given. Any information acquired by such parties is subject to the same restrictions covering original disclosures.

Disclosures without Patient's Written Consent

Although the best general rule of thumb to follow regarding disclosures is to obtain written consent whenever possible and for almost all situations, there are a few circumstances under which disclosures may be made without the patient's written consent. If written consent is not given, disclosure is allowed:

- When it is necessary for medical personnel to meet a medical emergency
- When it is authorized by a court order (accompanied by a subpoena), in which case information shall be limited to objective data necessary to meet the purposes for which the order is intended
- When treatment involves the use of any drug determined by the FDA to be dangerous to the life or health of the patient, in which case patient identifying information may be released to the FDA for purposes of notifying patients or their physicians
- For scientific research, management and financial audits, or program evaluation, but without disclosing in any report of such research, audit, or evaluation the identity of the drug abuser

In situations where oral disclosures are made without consent but in accordance with the regulations governing disclosure without patient consent, the program is to provide a written memorandum giving the patient's name, the nature of the emergency, the date and time of disclosure, the nature of the information disclosed, and the names of the individuals making and receiving such disclosures.

The Use of Central Registries

In certain areas of the country, central registries play an important part in treatment programs. The use of such registries, however, is prohibited unless they meet the definition of a permissible central registry and their use is for the purpose of preventing multiple enrollments in drug maintenance or detoxification programs. A "permissible central registry" is defined as a service organization that collects patient identifying information from two or more programs within the same state or not more than 125 miles from the nearest border of such state.

Information Obtained through Supervisory and Regulatory Processes

The following agencies are permitted access to program premises and records for the purpose of carrying out their specific functions in the supervision and regulation of drug maintenance and methadone detoxification programs: (1) Drug Enforcement Administration; (2) Food and Drug Administration; (3) state drug law enforcement agencies; and (4) state health authorities. (Other agencies, for example, funding agencies, may be granted access to records for purposes of audit and evaluation so long as this transaction is consistent with Sections 253 and 254 of the regulations.)

Patient identifying information obtained through these supervisory and regulatory processes may not be used in any registry or personal data bank of any sort, nor may it be otherwise disclosed.

Undercover Agents and Informants

Due to legal circumstances surrounding drug abuse, many patients enter treatment programs with a great deal of anxiety and suspicion. Consequently, the presence of undercover agents and informants can exercise considerable negative effects on program morale and effectiveness. In addition, the purpose of such agents is generally to secure information of the type protected by this legislation.

For the reasons indicated above, no undercover agents or informants may be employed or enrolled in any drug abuse treatment program, nor may the agent's supervisor knowingly permit the infiltration of such programs; the use of informants is equally prohibited. An informant may, however, enroll in a treatment program as a client for his own benefit.

Since there is always a possibility that medical personnel may become involved in the illegal sale of drugs, an exception to the above prohibitions is provided in order that sufficient evidence may be obtained for successful prosecution. In the case where criminal conduct is believed to be carried on by an employee of the program with the program director's knowledge of involvement, a court order may be issued without notice authorizing the use of undercover agents and informants.

Conclusion

All efforts should be made to maintain patient records in the utmost confidence. When there is a need for disclosure, written consent is almost always required with the exception of situations noted specifically in this section. When in doubt, obtain a written consent for the protection of both you and the patient.

It should be kept in mind that the restrictions and prohibitions set forth apply to all personnel, both while in the program and after leaving employment. The same restrictions apply to all outside parties associated with the program (e.g., auditors, researchers, evaluators, third party payers, service organizations) and who are recipients of disclosures. In like manner, redisclosure by individuals within the program or by those associated with the program is protected by the same set of regulations governing original disclosures; the patient's consent is ordinarily needed for each subsequent disclosure. The regulations also require that generally when a disclosure of information is made, the information should be accompanied by a statement informing the recipient of his obligation to guard the confidentiality of the information and not to disclose it except as authorized by the regulations.

Any violations of these laws or regulations, according to provisions made by Congress, can result in penalties of not more than five hundred dollars ($500.00) for the first offense, and five thousand dollars ($5,000.00) for each subsequent offense. Subsequent offenses need not be identical to the first violation but can pertain to any violation under this section.

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federal register

TUESDAY, JULY 1, 1975

WASHINGTON, D.C.

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PART IV

THE NATIONAL ARCHIVES OF THE UNITED STATES • 1934 •

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

■

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

General Provisions

REPRINTED BY THE

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND
MENTAL HEALTH ADMINISTRATION

Title 42—Public Health

CHAPTER I—PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER A—GENERAL PROVISIONS

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

On May 9, 1975, the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention published in the FEDERAL REGISTER (40 FR 20522) a notice of proposed joint rulemaking setting forth a proposed new Part 2 of Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records.

Interested persons were invited to submit written comments, views, or arguments with respect to the proposed regulations within 30 days of the date of publication of that notice. All comments so submitted were carefully considered, and at various stages in the rulemaking process, the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected by the proposed regulations were consulted.

As finally adopted and set forth hereinafter, the regulations contain two major substantive changes from the May 9 proposal. The separate treatment of funding sources and third-party payers (§§ 2.21 and 2.37 of the proposed regulations) was abandoned as unworkable, primarily because the prohibitions which the proposed regulations would have placed on funding sources would have directly conflicted with requirements which have been proposed in implementation of Title XX of the Social Security Act (see proposed 45 CFR 228.63, 40 FR 16802, 16809, April 14, 1975). In lieu of this approach, § 2.37 has been revised to provide that funding sources and third-party payers maintaining drug or alcohol abuse patient records are subject to restrictions upon disclosure to the same extent and in the same manner as any other entity maintaining records which are within the scope of the authorizing legislation and this Part.

The other major change is in the area of criminal justice system referrals, and the grounds for the rules finally adopted are set forth in the basis and purpose section (§ 2.39–1) pertaining thereto. In connection with that change, it must be frankly acknowledged that the arguments set forth in the corresponding basis and purpose section (§ 2.40–1) of the May 9 proposal have merit. The final rule may in certain instances result in a compromise of the treatment process, if judges or other authorities in the criminal justice system overreact to information whose communication is allowed under the final rules but would have been prohibited under the proposed rules.

Against such an adverse effect, however, there must be weighed the very real advantage which genuine cooperation between community social service systems and the criminal justice system can yield for those whose lives are crippled and scarred by the consequences of their own criminal conduct. Governmental responses based on a pure medical model have not met with noticeably greater success than those based on a purely punitive approach, and it would be tragic if these rules were so constructed as to become a barrier to the development of better ways to deal with those who are caught up in a pattern of seriously antisocial behavior.

In addition to the foregoing major changes, the following minor policy changes were made.

Provisions relating to destruction or other disposition of records were dropped from § 2.21 (§ 2.22 in the May 9 proposal) as unnecessary except in the case of programs discontinuing operations.

The fixed limitation on the permissible duration of written consent for disclosure was dropped from § 2.31 in favor of a limitation to such duration as may be reasonably necessary to effectuate the purpose for which the consent is given.

The specification of crimes in § 2.65 for which a court order may be granted authorizing use of program records in the investigation or prosecution of a patient was broadened to cover any "extremely serious" crime, with those listed in the May 9 notice being retained as examples.

Finally, a number of clarifying, technical, and conforming changes were made in the May 9 proposal, but these are without significant substantive effect.

Accordingly, pursuant to the authority of section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended by Pub. L. 92–282 (21 U.S.C. 1175), and section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended by Pub. L. 93–282 (42 U.S.C. 4582), and under the authority delegated to the General Counsel of the Special Action Office for Drug Abuse Prevention (39 FR 17901, May 21, 1974), Subchapter A of Chapter I, Title 42, Code of Federal Regulations, is amended by inserting immediately after Part 1 thereof a new Part 2 to read as set forth below.

Effective date. These regulations shall be effective on August 1, 1975.

Dated: June 25, 1975.

R. MOORE,
Acting Assistant Secretary for Health, Department of Health, Education, and Welfare.

Approved: June 26, 1975.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

Dated: June 27, 1975.

GRASTY CREWS II,
General Counsel, Special Action Office for Drug Abuse Prevention.

Dated: June 27, 1975.

ROBERT L. DUPONT,
Director, Special Action Office for Drug Abuse Prevention.

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Subpart A—Introductory Statement

§ 2.1 Statutory authority—drug abuse.

(a) *Statutory provisions effective May 14, 1974.* Insofar as the provisions of this part pertain to any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research, such provisions are authorized under section 408 of Pub. L. 92–255, the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) as amended by section 303 of Pub. L. 93–282 (88 Stat. 137). That section reads as follows:

§ 408. Confidentiality of patient records.

(a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (c), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) The Director of the Special Action Office for Drug Abuse Prevention, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Director are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(b) *Amendments effective June 30, 1975.* Effective on the date specified in section 104 of the Drug Abuse Office and Treatment Act of 1972 (June 30, 1975), the first sentence of section 408(g) above, will be amended by striking "Director of the Special Action Office for Drug Abuse Prevention" and inserting in lieu thereof "Secretary of Health, Education, and Welfare", and the second sentence of such section will be amended by striking "Director" and inserting "Secretary" in lieu thereof. Also effective on that date, section 408, above, will be further amended by (1) striking out "The" and inserting in lieu thereof "Except as provided in subsection (h) of this section, the" in the first sentence of subsection (g) of such section; and (2) adding at the end of such section the following new subsection:

(h) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations established by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from drug abuse. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

§ 2.2 Statutory authority—alcohol abuse.

Insofar as the provisions of this part pertain to any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, such provisions are authorized under section 333 of Pub. L. 91–616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582), as amended by section 122(a) of Pub. L. 93–282, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (88 Stat. 131). As so amended, that section reads as follows:

CONFIDENTIALITY OF RECORDS

SEC. 333. (a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(h) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations prescribed by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from alcohol abuse or alcoholism. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

§ 2.3 Previous regulations as controlling authority.

Attention is called to the interpretative regulations, issued by the Special Action Office for Drug Abuse Prevention (37 FR 24636, November 17, 1972, as revised 38 FR 33744, December 6, 1973, referred to hereinafter in this part as the "previous regulations"). Those regulations have been given a special status as controlling authority by the provisions of section 303(d) of Pub. L. 93-282, as well as the references in the legislative history of that act to the precedents established under section 408 of Pub. L. 92-255. Such references appear at page 11 of House Committee Report No. 93-759 and at page H3563 of the Congressional Record for May 6, 1974. The latter citation is to a detailed analysis of the bill in its final form which was submitted for the Record by its floor manager, Chairman Staggers of the Interstate and Foreign Commerce Committee, when the bill was up for final action by the House of Representatives.

§ 2.4 General purposes.

(a) *Policy objectives.* The purpose of the regulations set forth in this part is to implement the authorizing legislation in a manner that, to the extent practicable, takes into account two streams of legal thought and social policy. One has to do with enhancing the quality and attractiveness of treatment systems. The other is concerned with the interests of patients as citizens, most particularly in regard to protecting their rights of privacy. Within each stream there are cross-currents, and it should come as no surprise that areas of turbulence are to be found at their confluence.

(b) *Limited purpose.* The regulations contained in this part are not intended to direct the manner in which substantive functions, such as research, treatment, and evaluation, should be carried out, but rather to define the minimum requirements for the protection of confidentiality of patient records which must be satisfied in connection with the conduct of those functions in order to carry out the purposes of the authorizing legislation. This does not mean that observance of only the minimum legal requirements is always the wisest course, but in framing these regulations, allowance has necessarily been made for a diversity of emphasis and approach in the many different jurisdictions and by the great variety of public and private agencies which must find a way to function within the limits here prescribed.

§ 2.5 Format.

(a) *Basis and purpose sections.* Each section setting forth rules on any given topic in Subparts B through E of this part is followed by a section setting forth their basis and purpose. In many cases, the basis and purpose section is itself an interpretative rule regarding the legal authority of the rulemakers. In other instances, it summarizes historical or evidentiary material relevant to the validity and interpretation of the section which precedes it.

(b) *Statutory rules fully incorporated.* Although, for convenience of reference, the statutory basis for this part is set out in full in §§ 2.1 and 2.2, the regulations in Subparts B through E of this part are intended to include all of the operative statutory provisions.

§ 2.6 Administration and enforcement in general.

It is not contemplated that any particular agency will be set up specifically to enforce compliance with this part. Programs which receive Federal grants may be monitored for compliance with this and other applicable Federal law as an incident to the grant administration process. Similarly, FDA inspections of methadone programs will include inspection for compliance with this part, which is incorporated by reference in the methadone regulation (21 CFR 310.505).

§ 2.7 Reports of violations.

Any violation may be reported to the United States Attorney for the judicial district in which the violation occurs. Violations on the part of methadone programs may be reported to the regional offices of the Food and Drug Administration. Violations on the part of a Federal grantee or contractor may be reported to the Federal agency monitoring the grant or contract.

Subpart B—General Provisions

§ 2.11 Definitions and usages.—Rules.

(a) *Authorizing legislation.* The term "authorizing legislation" means section 408 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) and section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582), as such sections may be amended and in effect from time to time.

(b) *Construction of terms.* The definitions and rules of construction set forth in this section are applicable for the purposes of this part. To the extent that they refer to terms used in the authorizing legislation, they are also applicable for the purposes of such legislation.

(c) *Alcohol abuse.* The term "alcohol abuse" includes alcoholism.

(d) *Drug abuse.* The term "drug abuse" includes drug addiction.

(e) *Diagnosis and treatment.* The terms "diagnosis" and "treatment" include interviewing, counselling, and any other services or activities carried on for the purpose of or as an incident to diagnosis, treatment, or rehabilitation with respect to drug abuse or alcohol abuse, whether or not conducted by a member of the medical profession.

(f) *Program.*

(1) The term "program", when referring to an individual or organization, means either an individual or an organization furnishing diagnosis, treatment, or referral for alcohol abuse or drug abuse.

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(2) The term "program", when not used in the sense defined in paragraph (f)(1), means a plan or procedure, whether functional or organizational, and whether or not governmental, for dealing with alcohol abuse or drug abuse problems from either an individual or a social standpoint.

(g) *Program evaluation.*

The term "program evaluation" means an evaluation of—

(1) The effectiveness, efficiency, compliance with applicable therapeutic, legal, or other standards, or other aspects of the performance, of a program as defined in paragraph (f)(1) of this section, or

(2) The validity, effectiveness, efficiency, practicability, or other aspects of the utility or success of a program in the sense defined in paragraph (f)(2) of this section.

(h) *Program director.* The term "program director" in the case of a program which is an individual means that individual, and in the case of a program which is an organization, the individual, if any, who is the principal, or, in the case of organizations consisting of partners or under the control of a board of directors, board of trustees or other governing body, the individual designated as program director, managing director, or otherwise vested with executive authority with respect to the organization.

(i) *Patient.* The term "patient" means any individual (whether referred to as a patient, client, or otherwise) who has applied for or been given diagnosis or treatment for drug abuse or alcohol abuse and includes any individual who, after arrest on a criminal charge, is interviewed and/or tested in connection with drug or alcohol abuse preliminary to a determination as to eligibility to participate in a treatment or rehabilitation program.

(j) *Patient identifying information.* The term "patient identifying information" means the name, address, social security number, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a patient identifying number assigned by a program.

(k) *Alcohol abuse or drug abuse prevention function.* The term "alcohol abuse or drug abuse prevention function" means any program or activity relating to alcohol abuse or drug abuse education, training, treatment, rehabilitation, or research, and includes any such function even when performed by an organization whose primary mission is in the field of law enforcement or is unrelated to alcohol or drugs.

(l) The term "person" means an individual, a partnership, a corporation, a trust, a Federal or State governmental agency, or any other legally cognizable entity.

(m) *Service organization.* The term "service organization" means a person which provides services to a program such as data processing, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services.

(n) *Qualified service organization.* The term "qualified service organization" means a service organization which has entered into a written agreement with a program pursuant to which the service organization—

(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the program about patients in the program, it is fully bound by the provisions of this part;

(2) undertakes to institute appropriate procedures for safeguarding such information, with particular reference to patient identifying information; and

(3) undertakes to resist in judicial proceedings any efforts to obtain access to information pertaining to patients otherwise than as expressly provided for in this part.

(o) *Records.* The term "records" includes any information, whether recorded or not, relating to a patient, received or acquired in connection with the performance of any alcohol abuse or drug abuse prevention function, whether such receipt or acquisition is by a program, a qualified service organization, or any other person.

(p) *Communications not constituting disclosure.* The following types of communications do not constitute disclosures of records:

(1) Communications of information within a program between or among personnel having a need for such information in connection with their duties.

(2) Communications between a program and a qualified service organization of information needed by the organization to perform its services to the program.

(3) Communications of information which includes neither patient identifying information nor identifying numbers assigned by the program to patients.

(q) *Previous regulations.* The term "previous regulations" refers to the interpretative regulations issued by the Special Action Office for Drug Abuse Prevention, originally published November 17, 1972, 37 FR 24636, as revised December 6, 1973, 38 FR 33744.

(r) *State law.* The term "State law" refers to the law of a State or other jurisdiction, such as the District of Columbia, as distinguished from Federal law in general. As applied to transactions which do not take place in any State or other similar jurisdiction, the term refers to Federal common law as modified by any applicable Federal statutes and regulations.

(s) *Third party payer.* The term "third party payer" means any organization (or person acting as agent or trustee for an organization or fund) which pays or agrees to pay for diagnosis or treatment furnished or to be furnished to a particular individual, where such payment or agreement to pay is on the basis of an individual relationship between the payer and the patient (or a member of the patient's family in the case of self-and-family insurance coverage or similar arrangements) evidenced by a contract, an insurance policy, a certificate of membership or participation, or similar documentation.

(t) *Funding source.* The term "funding source" means any individual or any public or private organization, including any Federal, State, or local governmental agency, which makes payments in support of a program. A funding source is not, as such, a third party payer, even where its payment sare based directly or indirectly on the program's patient load with or without respect to specified categories of eligible persons.

(u) *August 22, 1974 draft.* References to the "August 22, 1974 draft" are to the draft regulations set out in the Advance Notice of Proposed Joint Rulemaking published in the FEDERAL REGISTER on August 22, 1974, 39 FR 30426, by the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention.

§ 2.11–1 Definitions and usages.—Basis and purpose.

(a) *In general.* The definitions are based upon the legislative history of and experience with the authorizing legislation, and are intended as aids to construing the provisions of this part to carry out the purposes of those statutes.

(b) *Coverage of applicants for treatment.* Section 2.11(i) is intended to make it clear that records of the identity and other information about a person whose application is rejected or withdrawn are fully as much covered by this part as records pertaining to a patient actually accepted for treatment.

(c) *Program terminology for patients not controlling.* While many programs prefer to use "client" or some other term instead of "patient" to describe the recipients of their services, it is believed preferable to use terminology in this part which is consistent with that used in the authorizing legislation. It should be clearly understood, however, that the records of any individual who fits the definition set forth in § 2.11(i) are covered, no matter what terminology the program may use to designate his status.

(d) *Origin of "prevention function" terminology.* The definition of alcohol abuse or drug abuse prevention function in § 2.11(k) is adapted from the definition of drug abuse prevention function in section 103(b) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1103(b)). Although there was no corresponding defined term available to the draftsman of the 1974 amendment to section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582), it is clear from the legislative history that the coverage of alcohol abuse patient records was intended to be fully as wide as the coverage of drug abuse patient records, and the definition in § 2.11(k) reflects that intention.

(e) *Ambiguity of the term "program".* It is recognized that it is ordinarily poor drafting technique to use the same term in senses which are as different, yet related, as those in §§ 2.11(f)(1) and 2.11(f)(2). This part, however, has to be read both in conjunction with the Food and Drug Administration's Methadone Regulation and the Drug Abuse Office and Treatment Act of 1972. The Methadone Regulation (21 CFR 310.505) clearly uses the term "program" in the § 2.11(f)(1) sense. In section 103(b) of the Act (21 U.S.C. 1103(b)), it is clearly used in the § 2.11(f)(2) sense, and the usage in section 408(b)(2)(B) of the Act has from its original enactment been administratively interpreted to include both senses. As used in this part, the context should indicate the intended meanings with sufficient clarity to make this preferable to creating and defining new terminology which would be different from that used in related regulations and the authorizing legislation.

(f) *Construction of disclosures.* Section 2.11(p) is intended to clarify the status of communications which are carried on within a program or between a program and persons or organizations which are assisting it in providing patient care. The authorizing legislation was not intended to prohibit programs from carrying on accepted practices in terms of obtaining specialized services from outside organizations. In conjunction with the definition of qualified service organizations, set forth in § 2.11(n), the provisions of § 2.11(p) should prevent the development of abuses in this area.

§ 2.12 Applicability.—Rules.

(a) *In general.* Except as provided in paragraph (b) of this section, this part applies to records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any alcohol abuse or drug abuse prevention function—

(1) Which is conducted in whole or in part, whether directly or by grant, contract, or otherwise, by any department or agency of the United States,

(2) For the lawful conduct of which in whole or part any license, registration, application, or other authorization is required to be granted or approved by any department or agency of the United States,

(3) Which is assisted by funds supplied by any department or agency of the United States, whether directly through a grant, contract, or otherwise, or indirectly by funds supplied to a State or local government unit through the medium of contracts, grants of any description, general or special revenue sharing, or otherwise, or

(4) Which is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program conducting such function, or by a way of a tax-exempt status for such program.

(b) *Armed Forces and Veterans' Administration.*

(1) The provisions of this part do not apply to any interchange, entirely within the Armed Forces, within those components of the Veterans' Administration furnishing health care to veterans, or between such components and the Armed Forces, of records pertaining to a person relating to a period when such person is or was subject to the Uniform Code of Military Justice.

(2) Except as provided in paragraph (b)(1) of this section, this part applies to any communication between any person outside the Armed Forces and any person within the Armed Forces.

(3) Except as provided in paragraph (b)(1) of this section, this part applies, insofar as it pertains to any drug abuse prevention function, to any communication between any person outside those components of the Veterans' Administration furnishing health care to veterans and any person within such components, until such date as the Secretary of Health, Education and Welfare exercises his authority (conferred by an amendment effective June 30, 1975) to prescribe regulations under section 408 of Pub. L. 92-255 (21 U.S.C. 1175). After such date, this part applies thereto to such extent as the Administrator of Veterans' Affairs, through the Chief Medical Director, by regulation makes the provisions of this part applicable thereto.

(4) Except as provided in paragraph (b)(1) of this section, this part applies, insofar as it pertains to any alcohol abuse prevention function, to any communication between any person outside those components of the Veterans' Administration furnishing health care to veterans and any person within such components, to such extent as the Administrator of Veterans' Affairs, through the Chief Medical Director, by regulation makes the provisions of this part applicable thereto.

(c) *Period covered as affecting applicability.* The provisions of this part apply to records of identity, diagnosis, prognosis, or treatment pertaining to any given individual maintained over any period of time which, irrespective of when it begins, does not end before March 21, 1972, in the case of diagnosis or treatment for drug abuse or before May 14, 1974, in the case of diagnosis or treatment for alcohol abuse.

(d) *Applicability determined by nature and purpose of records.* The applicability of the provisions of this part is determined by the nature and purpose of the records in question, and not by the status or primary functional capacity of the recordkeeper.

§ 2.12-1 Applicability.—Basis and purpose.

(a) The broad coverage provided by § 2.12(a) is appropriate in the light of the remedial purposes of the statutes as well as the practical desirability of certainty and uniformity. Sections 2.12(a)(1) and 2.12(a)(2) simply follow the terms of subsection (a) of the statutes, with some explanatory material for the sake of clarity and explicitness.

(b) Sections 2.12(a)(3) and 2.12(a)(4) are based upon the use by Congress of the phrase "directly or indirectly assisted by any department or agency of the United States". In the light of the multiplicity and extent of Federal programs and policies which can be of assistance to drug and alcoholism programs, this wording strongly suggests an intention to provide the broadest coverage consistent with the literal terms of the statutes. Many programs commence with direct Federal assistance, financial, technical, or both, and later continue with State aid and private, tax-deductible contributions. It would be manifestly contrary to the general policy sought to be effectuated by the legislation if the confidential status of a program's records were to terminate, or even be called into question, by the cessation of direct Federal assistance.

(c) With regard to § 212(a)(3), it seems clear that whenever a State or local government is assisted by the Federal government by way of revenue sharing or other unrestricted grants, all of the programs and activities of the State or local government are thereby indirectly assisted, and thus meet that aspect of the statutory criteria for coverage.

(d) Section 2.12(a)(4) follows the doctrine established in *McGlotten v. Connally*, 338 F. Supp. 448 (D.C. D.C., 1972), in which it was held that the deductible status of contributions to an organization constitutes "Federal financial assistance" within the meaning of section 601 of the 1964 Civil Rights Act (42 U.S.C. 2000d). The inclusion of the adjective "indirect" as a modifier of the term "assistance" as used in the provisions of law authorizing this part suggests an intention to provide coverage at least as broad, if not broader than, section 601 of the Civil Rights Act in respect of financial assistance. See, also, *Green v. Connally*, 330 F. Supp. 1150 (D.C. D.C., 1971) aff'd sub. nom. *Coit v Green*, 404 U.S. 997, 92 S. Ct. 564, 30 L. Ed. 2d 550 (1971).

(e) Section 2.12(b) essentially repeats the interpretation given in § 1401.02(b) of the previous regulation except that it takes account of the special provisions inserted in the new law with reference to the Veterans Administration, and makes clear that the exemption for communications within the military-VA system does not generally apply to records pertaining to civilians.

(f) Section 2.12(c), which deals with the question of how the period covered by any given set of records affects the applicability of these regulations to them, restates the principle set forth in § 1401.02(a) of the previous regulations, and applies it to records in the field of alcohol abuse as well as drug abuse. The authorizing legislation contains no effective date provisions. A construction which would apply the statutes to records of completely closed treatment episodes, records necessarily made and maintained prior to the enactment of the legislation, would create serious administrative problems. It seems doubtful, in any case, whether such records have been "maintained," within the meaning of the statutes, during any period of time after their enactment. On the other hand, if treatment is actually carried on after the enactment of the applicable statute, then all the records should be covered irrespective of when treatment was begun, because such records clearly are being "maintained" after the enactment of the legislation.

(g) Section 2.12(d) has been included to make explicit one of the legal implications of the authorizing legislation, which is cast in terms descriptive of the records which are to be confidential rather than of the recordkeepers on whom a duty is thus imposed. The result is that, for example, where a State agency maintains an individual client record which contains identifying information about a client (i.e., patient) receiving treatment or rehabilitation services for drug abuse, such a record is clearly a record maintained in connection with a drug abuse prevention function, and is subject to the provisions of this part. The fact that the record may also be required by statute or regulations pertaining to eligibility for Federal Financial Participation would in no way exempt the record from the prohibitions and requirements of this part. Thus, it would be unlawful and a violation of these regulations for such a record to be made available to a law enforcement agency, or to determine (without the prior written consent of the client) eligibility for other welfare benefits, or for any other administrative or investigative uses or purposes which would involve or result in an identification of the client to a third party.

§ 2.13 General rules regarding confidentiality.—Rules.

(a) *In general.* Records to which this part applies shall be confidential and may be disclosed only as authorized by this part, and may not otherwise be divulged in any civil, criminal, administrative, or legislative proceeding conducted by any Federal, State, or local authority, whether such proceeding is commenced before or after the effective date of this part.

(b) *Unconditional compliance required.* The prohibition upon unauthorized disclosure applies irrespective of whether the person seeking disclosure already has the information sought, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other justification or basis for disclosure not expressly authorized under this part.

(c) *Information covered by prohibition.* The prohibition on unauthorized disclosure covers all information about patients, including their attendance or absence, physical whereabouts, or status as patients, whether or not recorded, in the possession of program personnel, except as provided in paragraph (d) of this section.

(d) *Crimes on program premises or against program personnel.* Where a patient commits or threatens to commit a crime on the premises of the program or against personnel of the program, nothing in this part shall be construed as prohibiting personnel of the program from seeking the assistance of, or reporting such crime to, a law enforcement agency, but such report shall not identify the suspect as a patient. In any such situation, immediate consideration should be given to seeking an order under Subpart E of this part to permit the disclosure of such limited information about the patient as may be necessary under the circumstances.

(e) *Implicit and negative disclosures prohibited.* The disclosure that a person (whether actual or fictitious) answering to a particular description, name, or other identification is not or has not been attending a program, whether over a period of time or on a particular occasion, is fully as much subject to the prohibitions and conditions of this part as a disclosure that such a person is or has been attending such a program. Any improper or unauthorized request for any disclosure of records or information subject to this part must be met by a noncommittal response.

(f) *In-patients and residents.* The presence of any in-patient in a medical facility or resident in a residential facility for the treatment of drug or alcohol abuse may be acknowledged to callers and visitors with his written consent. Without such consent, the presence of any in-patient or resident in a facility for the treatment of a variety of conditions may be acknowledged if done in such a way as not to indicate that the patient is being treated for drug or alcohol abuse.

§ 2.13–1 General rules regarding confidentiality.—Basis and purpose.

(a) Section 2.13(a) enunciates the general principle of the statutory provisions, and is unchanged from § 1401.03 of the previous regulations.

(b) Sections 2.13(b) and 2.13(c) have been added on the basis of written comments on the draft regulations published August 22, 1974, in which there was a documented report that counsel for a program had advised the program that it could furnish information to the FBI about patients without their written consent and without completing a full judicial proceeding in accordance with Subpart E of this part. Sections 2.13(b) and 2.13(c) should clarify the original intent of the statutes and regulations to the extent of precluding such errors in the future.

(c) In the situation described in § 2.13(d), the desirability of the general prophylactic rule prohibiting disclosures by program personnel about patients regardless of whether such disclosures are from a written record must yield to the practical necessity to permit protection from, and prompt reporting of, criminal acts. In the preface to the first set of regulations issued under 21 U.S.C. 1175, it was emphasized that the operation of that section "in no way creates a sanctuary for criminals." (37 FR 24636, November 17, 1972). Section 2.13(d) is consistent with that contemporaneous administrative construction.

(d) Section 2.13(e) is adapted from § 1401.11 of the August 22, 1974 draft. The suggestion that this part be cited when declining to give information has been deleted on the basis of comments that correctly pointed out that such a citation, if given by an institution or program maintaining some records covered by this part and some not, would serve to identify the records inquired about as pertaining to treatment covered by this part.

Section 2.13(f) merely clarifies the effect of the preceding paragraphs in the special situations to which paragraph (f) relates.

§ 2.14 Penalty for violations.—Rules.

(a) *Penalty provided by law.* Any person who violates any provision of the authorizing legislation or any provision of this part shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(b) *Application to subsequent offenses.* Where a defendant has committed one offense under either section authorizing this part or any provision of this part authorized by that section, any offense thereafter committed under the same section or any provision of this part authorized under that section shall be treated as a subsequent offense.

§ 2.14–1 Penalty for violations.—Basis and purpose.

(a) Section 2.14 states the criminal penalty provided for in subsection (f) of the sections authorizing this part. It is included in this part for convenience and completeness. Some of the comments received on this section when originally proposed suggested that criminal penalties for violation should include imprisonment, but such a change would have to be made by legislation rather than rulemaking.

(b) Section 2.14(b) clarifies the intention that the "subsequent offense" need not be identical to the first offense, as long as it is committed with respect to the same statutory section. For example, a person whose first offense had consisted of improperly releasing the name of a patient in an alcoholism treatment program would be punishable for a "subsequent offense" if he later gives out information from the diagnostic work-up of an alcoholism patient.

§ 2.15 Minor patients.—Rules.

(a) *Definition of minor.* The term "minor" means a person who has not attained the age of 18 years or, in a State where a different age is expressly provided by State law as the age at which a person ceases to be a minor, the age prescribed by the law of such State.

(b) *Consent to disclosure in general.* Except as provided in paragraph (c), where consent is required for any disclosure under this part, such consent in the case of a minor must be given by both the minor and his parent, guardian, or other person authorized under State law to act in his behalf, but any disclosure made after the patient has ceased to be a minor may be consented to only by the patient.

(c) *Rule when State law authorizes treatment without parental consent.* Whenever a patient, acting alone, has the legal capacity under the applicable State law to apply for and obtain such diagnosis, counselling, administration of medication, or other services as actually are or were provided to him by the program with respect to which he is or was a patient, any consent required for disclosure under this part may be given only by the patient, notwithstanding the fact that the patient may be a minor.

(d) *Initial contacts.* When a minor applies for services under circumstances other than those described in paragraph (c) of this section, the fact of such application may not be disclosed, except as an incident to a communication authorized under paragraph (f) of this section, without consent of the applicant, to the applicant's parent, guardian, or other person authorized under State law to act on behalf of the applicant. When such an applicant refuses consent, it must be explained to the applicant that while he or she has the right (subject to the provisions of paragraph (f) of this section) to withhold such consent, the services applied for cannot be provided without it.

(e) *Collection or attempted collection of payment for services.* Where State law authorizes the furnishing of services to a minor without the consent of the minor's parent or guardian, no inquiry may be made of the parent's or guardian's financial responsibility, and no bill, statement, request for payment, or any other communication in respect of such services may be transmitted directly or indirectly to such parent or guardian, without the express written consent of the patient. Such consent may not be made a condition of the furnishing of services except in the case of a program which is not required by law, and does not in fact hold itself out as willing, to furnish services irrespective of ability to pay.

(f) *Applicant lacking capacity for rational choice.* When, in the judgment of a program director a minor applicant for services, because of extreme youth or mental or physical condition, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, and the situation of the applicant poses a substantial threat to the life or physical well being of the applicant or any other individual, and such threat might be reduced by communicating the relevant facts to a parent or guardian of the applicant, such facts may be so communicated by the program director or by program personnel authorized by the director to do so.

§ 2.15–1 Minor patients.—Basis and purpose.

(a) The statutes authorizing this part are totally silent on the issue of the capacity of a minor to give consent for disclosures, and there is nothing in the legislative history to suggest that the question was ever considered by Congress. The question is, however, one which arises repeatedly, and it is therefore appropriately addressed under the general rulemaking authority conferred by subsection (g) of the authorizing legislation.

(b) Perhaps no legal issues are more highly charged than those affecting the relationship of parent and child. Since Congress has not evidenced an intention to affect this relationship, it is clear that local law should govern, and the task of rulemaking is limited to that of insuring, as far as possible, that the results under Federal law are consistent with local policy.

(c) Where a State has authorized the furnishing of treatment or other services of a given type to a minor without notice to or consent by the parent or guardian, it seems clear that a consistent Federal policy with respect to disclosure requires that consent for any disclosure of the treatment record be given by the minor. This policy, moreover, should not be frustrated by attempts to enforce parental financial responsibility in a situation where the State itself has determined that the minor should have a right to obtain services without involving the parent.

(d) A much more difficult problem is presented in the case of a minor who applies for services in a jurisdiction which has not determined that a minor should have the right to obtain them without parental knowledge or consent. The question may arise as to whether the clinician has an ethical or legal duty to notify the parent which conflicts with a duty of nondisclosure. The rules in § 2.15 are based upon the theory that Federal law should not invalidate a State policy which prohibits treatment without parental consent, but that keeping confidential a mere application for treatment is not ordinarily a sufficient transgression of such a State policy as to require an exception to the general Federal policy prohibiting disclosure of an application for services without the consent of the applicant.

(e) Section 2.15(f) deals with the case of the minor applicant who lacks the capacity to make a rational choice about consenting to disclosure. It is based upon the theory that where a person is actually as well as legally incapable of acting in his own interest, disclosures to a person who is legally responsible for him may be made to the extent that the best interests of the patient clearly so require. Any other rule could subject clinicians to an intolerable choice between violating the provisions of this part on the one hand, or failing to take action to avoid a preventable tragedy involving a minor, on the other. The statutes authorizing this part should not be read as requiring such a choice.

§ 2.16 Incompetent and deceased patients.—Rules.

(a) *Incompetent patients other than minors.* Where consent is required for any disclosure under this part, such consent in the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(b) *Deceased patients.*

(1) *In general.* Except as provided in paragraph (b)(2) of this section, where consent is required for any disclosure of this part, such consent in the case of records of a deceased patient may be given by an executor, administrator, or other personal representative. If there is no appointment of a personal representative, such consent may be given by the patient's spouse, or if none, by any responsible member of the patient's family.

(2) *Vital statistics.* In the case of a deceased patient, disclosures required under Federal or State laws involving the collection of death and other vital statistics may be made without consent.

§ 2.16–1 Incompetent and deceased patients.—Basis and purpose.

Section 2.16 essentially repeats the substance of § 1401.04 of the previous regulations, broadened to reflect the fact that the statutes now allow any consensual disclosures permitted by the regulations, and to cover the situation of deceased patients for whom no formal appointment of an executor, administrator, or other personal representative has been made. Written comments were received to the effect that the power to consent to disclosure in the case of a deceased patient should be limited to a personal representative. The expense of probate or administration in some jurisdictions could cause financial hardship to survivors, and on balance it is believed that where the assets of an estate are insufficient to justify the appointment of a personal representative, the public interest is served by permitting others to consent to disclosure.

§ 2.17 Security precautions.—Rules.

(a) *Precautions required.* Appropriate precautions must be taken for the security of records to which this part applies. Records containing any information pertaining to patients shall be kept in a secure room, or in a locked file cabinet, safe, or other similar container, when not in use.

(b) *Policies and procedures.* Depending upon the type and size of the program, appropriate policies and procedures should be instituted for the further security of records. For example, except where this function is personally performed by the program director, a single member of the program staff should be designated to process inquiries and requests for patient information, and a written procedure should be in effect regulating and controlling access by those members of the staff whose responsibilities require such access, and providing for accountability.

§ 2.17–1 Security precautions.—Basis and purpose.

The enormous variations in both the size and the type of programs to which this part is applicable preclude the formulation of specific requirements with respect to the physical security of records. Almost any requirement which could be laid down would, under some circumstances, either be impracticable or perverse in its effects. For example, in a facility handling a variety of medical records, all of which are confidential and so marked, a requirement that those pertaining to drug or alcohol treatment be marked in any distinctive way would merely serve to identify such records as pertaining to drug or alcohol treatment—precisely the opposite of the intended result. The purpose of § 2.17, which is based upon § 1401.25 of the previous regulations, is to alert programs to the necessity of exercising due care with respect to the security of patient records.

§ 2.18 Extent of disclosure.—Rule.

Any disclosure made under this part, whether with or without the patient's consent, shall be limited to information necessary in the light of the need or purpose for the disclosure.

§ 2.18–1 Extent of disclosure.—Basis and purpose.

(a) Section 2.18 expresses the general principle, which has application in many different contexts, that any disclosure from records covered by this part should be limited to information necessary in the light of the need or purpose for the disclosure. It is identical to § 1401.06 of the previous regulations.

(b) This section should not be misunderstood as imposing a limitation on the scope of records which may or should be made available to health agencies conducting inspections as described in § 2.55. All of the records maintained by a program may be relevant to such inspection. The Congress has determined that disclosure under such circumstances is not a violation of the statutes authorizing this part; where such disclosure is required by Federal or State law, and the inspecting agency is a qualified State health agency as defined in § 2.55(e)(1), it becomes the responsibility of that agency to protect the confidentiality of information it acquires in the course of its lawful activities.

§ 2.19 Undercover agents and informants.—Rules.

(a) *Definitions.* As used in this section, § 2.19–1, and §§ 2.67 and 2.67–1,—

(1) The term "undercover agent" means a member of any Federal, State, or local law enforcement or investigative agency whose identity as such is concealed from either the patients or personnel of a program in which he enrolls or attempts to enroll.

(2) The term "informant" means a person who, at the request of a Federal, State, or local law enforcement or investigative agency or officer, carries on observation of one or more persons enrolled in or employed by a program in which he is enrolled or employed, for the purpose of reporting to such agency or officer information concerning such persons which he obtains as a result of such observation subsequent to such request.

(b) *General prohibition.* Except as otherwise provided in paragraph (c) of this section, or as specifically authorized by a court order granted under § 2.67,—

(1) No undercover agent or informant may be employed by or enrolled in any alcohol or drug abuse treatment program;

(2) No supervisor or other person having authority over an undercover agent may knowingly permit such agent to be or remain employed by or enrolled in any such program; and

(3) No law enforcement or investigative officer may recruit or retain an informant with respect to such a program.

(c) *Exceptions.* The enrollment of a law enforcement officer in a treatment program shall not be deemed a violation of this section if (1) such enrollment is solely for the purpose of enabling the officer to obtain treatment for his own abuse of alcohol or drugs, and (2) his status as a law enforcement officer is known to the program director.

§ 2.19–1 Undercover agents and informants.—Basis and purpose.

(a) In many instances, persons who are patients in treatment programs are making their first tentative efforts toward re-integration into productive society. They may be both vulnerable and suspicious, and the presence in a treatment program of undercover law enforcement agents or informants can have a devastating effect on the program's morale and therapeutic effectiveness. Moreover, it would appear that the purpose of such agents or informants may be to obtain precisely the type of personal information which might be revealed by inspection of counselor notes and other patient records maintained by the program. Thus, the placing of an undercover agent or informant in a program, either as a patient or as an employee, would appear to be contrary to the purposes for which the provisions of law authorizing this part were enacted, and properly subject to prohibition under regulations expressly authorized to carry out those purposes.

(b) From a policy standpoint, § 2.19 is based on the reasoning that while the use of undercover agents and informants in treatment programs is ordinarily to be avoided, there may occasionally arise circumstances where their use may be justified. Accordingly, where a showing is made in an application for an order under § 2.67 that the criteria set forth in that section are satisfied, the court may grant such an order.

(c) When this section of the regulations was proposed, numerous written comments were received urging that there be an absolute prohibition on the use of undercover agents and informants, and most of the witnesses at the hearings who addressed the issue at all testified to the same effect. A number of comments were received to the effect that § 2.19 should be dropped altogether, but this request was always clearly and often explicitly predicated on the assumption that failure to say anything about undercover agents and informants would make their use illegal. Our view is to the contrary: we think that the statutes, standing alone, do not prohibit the practice, and thus that in the absence of a specific prohibition in these regulations, the use of undercover agents and informants in treatment programs would not be unlawful. Since this is a view which we believe to be shared by the law enforcement and investigative agencies which are affected by § 2.19, there is as a practical matter no alternative to predicating these regulations upon its correctness.

(d) However desirable it may be to limit the use of undercover agents and informants in treatment programs, we think a strong argument can be made against our power to impose an absolute prohibition. To the extent that the practice is susceptible to regulation through the rulemaking process at all, it is on the theory that it opens the way to disclosure of information which is or should be in program records, and thus is contrary to the purposes of the statutes. Since subsection (g) of the statutes confers express rulemaking authority to carry out these purposes, regulation of the use of undercover agents and informants is a proper subject for the exercise of that authority. But even the express statutory prohibition against direct disclosure of the content of patient records is subject to the power of the courts to authorize such disclosure under subsection (b)(2)(C) of the statutes. It seems difficult to argue that Congress intended to confer on rulemaking agencies the authority to impose an absolute prohibition even though its own restrictions (other than those on disclosures of patient identities from secondary records) are subject to being set aside by court order in particular cases. Since we have not attempted to exercise such an authority, it is not necessary to decide at this time whether it was conferred.

(e) A careful reading of the definitions set forth in § 2.19(a) is crucial to an understanding of the prohibitions which are imposed by § 2.19. Objections to the section were made informally but vigorously on behalf of the Drug Enforcement Administration, on the ground that the testimony of informants or undercover agents is frequently if not normally essential to the successful prosecution of cases arising under the Controlled Substances Act. It was said that in the form originally proposed, the section would cut off from treatment those who might agree to cooperate with law enforcement authorities, a result both inhumane and counterproductive. As the definition of an informant is intended to make clear, however, it is his function vis-a-vis personnel and fellow patients in the program in which he is enrolled which is controlling, and not his relationship, *per se*, with an investigative agency.

(f) Finally, the definition of informant is intended to clarify the distinction between an informant and an ordinary witness. It is the element of prearrangement which is crucial. In one of the comments received on § 2.19 as proposed, it was urged that treatment programs should be considered as sanctuaries, but such a result was explicitly disclaimed in the initial publication of the previous regulations (37 FR 24636). In so saying, we are by no means insensitive to the anxieties repeatedly expressed in both testimony and comments on this section, but we believe that the prohibition contained in § 2.19 and the procedures and criteria set forth in § 2.67 provide a measure of relief which is consistent with the structure and intent of the underlying statutes.

§ 2.20 Identification cards.—Rules.

(a) *Required use prohibited.* No program may require or request any patient to carry in his or her possession, while away from the program premises, an identification card or other form of identification which is issued by the program or which would tend to identify the bearer as a participant in it or any similar program.

(b) *Conditions of voluntary use.* Nothing in this section prohibits a program from issuing an identification card to a patient if the patient's counsellor or other authorized member of the program staff has explained to the patient that acceptance and use of the card is entirely voluntary and that neither an initial rejection nor a subsequent discontinuation of its use will in any way prejudice his or her record or standing in the program. In the case of any patient to whom an identification card or similar device was issued prior to the effective date of this section, or subsequent thereto in violation of this section, a counsellor or other authorized member of the program staff shall explain to the patient his right to turn it in without prejudice at any time.

(c) *On-premises exemption.* Nothing in this section prohibits a program from maintaining and using on its premises cards, photographs, tickets, or other devices, or using passwords or other information, to assure positive identification of patients, correct recording of attendance or medication, or for other proper purposes, as long as no pressure is brought on any patient to carry any such device when away from the program premises.

§ 2.20–1 Identification cards.—Basis and purpose.

Section 2.20 is in furtherance of one of the basic purposes of the statutes authorizing this part, namely, protection of patients from improper disclosure of their status as such. Regrettably, there appear to be areas where possession of a treatment program identification card can be prejudicial to a person under arrest or subjected to a search. In any part of the country, the accidental display or circulation of such a card by reason of its loss or theft could have adverse consequences for a variety of reasons. Since programs have other means of achieving the ends which identification cards are meant to serve, patients who do not wish to assume whatever risks may be involved in carrying such cards should not be compelled to do so.

§ 2.21 Disposition of discontinued program records.—Rules.

(a) *General rule.* When a program discontinues operations or is taken over or acquired by another program, its records to which this part applies with respect to any patient may, with the written consent of that patient, be turned over to the acquiring program or, if none, to any other program specified in the patient's consent. Except as otherwise provided in this section, any records to which this part applies, but for the transfer of which patient consent is not obtained, shall be either completely purged of patient identifying information, or destroyed. If any effort to obtain consent for transfer is made, it shall be by means which minimize the likelihood of accidental or incidental disclosure to any third party of the patient's identity as such.

(b) *Retention period.* Where records are required by law to be kept for a specified period, and such period does not expire until after the discontinuation or acquisition of the program, and patient consent for their transfer is not obtained, such records shall be sealed in envelopes or other containers marked or labelled as follows: "Records of [insert name of program] required to be maintained pursuant to [insert citation to law or regulation requiring that records be kept] until a date not later than December 31, [insert appropriate year]." The same procedure may be followed when it is determined to retain records for the period of any applicable statute of limitations.

(c) *Custodial retention.* Records marked and sealed in accordance with paragraph (b) of this section may be held by any lawful custodian, but may be disclosed by such custodian only under such circumstances and to such extent as would be permissible for the program in which they originated. As soon as practicable after the date specified on the label or legend required to be affixed pursuant to paragraph (b) of this section, the custodian shall destroy the records. In the case of any program terminated by reason of bankruptcy, the expense of compliance with this paragraph shall be an expense of administration of the bankrupt estate.

§ 2.21–1 Disposition of discontinued program records.—Basis and purpose.

While arguments can be made for requiring the destruction of records at the conclusion of their useful clinical life, there is wide disagreement on its span, and there are in addition research considerations which argue for an even longer period of retention. Except in the case of discontinued programs, it therefore seems best to leave this issue for determination by the programs concerned.

§ 2.22 Former employees and others.—Rules.

The prohibitions of this part on disclosure of patient records or information contained therein apply to all individuals who are personnel of treatment programs, researchers, auditors, evaluators, service organizations, or others having access to such records or information, and continue to apply to such individuals with respect to such records or information after the termination of their employment or other relationship or activity giving rise to such access.

§ 2.22–1 Former employees and others.—Basis and purpose.

The probition contained in § 2.22 is arguably an interpretation of the authorizing legislation which would be necessary as a matter of law even in the absence of this part; its validity as an exercise of the rulemaking power conferred by subsection (g) of the authorizing legislation seems beyond dispute.

§ 2.23 Relationship to State laws.—Rules.

The enactment of the provisions of law authorizing this part was not intended to preempt the field of law covered thereby to the exclusion of State laws not in conflict therewith. If a disclosure permitted under the provisions of this part, or under a court order issued pursuant thereto, is prohibited under State law, nothing in this part or in the provisions of law authorizing this part may be construed to authorize any violation of such State law. No State law, however, may either authorize or compel any disclosure prohibited by this part.

§ 2.23–1 Relationship to State laws.—Basis and purpose.

Section 2.23 sets forth publicly an interpretation which, in informal communications, has consistently been given to 21 U.S.C. 1175 since its original enactment, and clearly has equal applicability to 42 U.S.C. 4582.

§ 2.24 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act.—Rules.

(a) *Research privilege description.* In some instances, there may be concurrent coverage of a program or activity by the provisions of this part and by a regulation or other administrative action under section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c)). The latter two provisions of law, referred to hereinafter in this section as the research privilege sections, confer on the Secretary of Health, Education, and Welfare, and on the Attorney General, respectively, the power to authorize researchers to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subject of such research. The Secretary of Health, Education, and Welfare may grant this privilege with respect to any "research on mental health, including research on the use and effect of alcohol and other psychoactive drugs." The Attorney General's power is conferred as part of a section authorizing research related to enforcement of laws under his jurisdiction concerning substances which are or may be subject to control under the Controlled Substances Act, but is not expressly limited to such research. Regardless of whether a grant of research privilege is made by the Secretary or by the Attorney General, it is expressly provided that persons who obtain it "may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding to identify" the subjects of research for which the privilege was obtained.

(b) *Comparison with authority for this part.* Although they deal, in a sense, with the same subject matter, and may on occasion concurrently cover the same transactions, it is important to note the differences between the research privilege sections (21 U.S.C. 872(c) and 42 U.S.C. 242a(a)) and the provisions of law (21 U.S.C. 1175 and 42 U.S.C. 4582) which authorize this part. Briefly, these differences are as follows:

(1) Although they contain broad grants of express rulemaking authority, the provisions of law by which this part is authorized are self-executing in the sense that they are operative irrespective of whether the rulemaking authority is exercised. The protection afforded by the research privilege sections, on the other hand, can only come into existence as a result of affirmative administrative action.

(2) The provisions of law authorizing this part, as well as the provisions of this part itself, impose affirmative duties with respect to the records to which they apply, and the violation of such duties is subject to criminal penalties. To the extent that a privilege is thereby created, it grows out of the duties thus imposed. The research privilege sections, by contrast, impose no duties by their own terms, and if any duties are implied from their existence, they would have to be enforced on the basis of an implicit civil liability for damages or by equitable relief, as there are no criminal or administrative sanctions available.

(3) The exercise of the authority conferred by the research privilege sections is subject to administrative discretion, whereas in the case of the duties imposed under this part there is judicial discretion, within the limits and subject to procedures and criteria prescribed by statute and regulation, to grant relief in particular cases.

(c) *Grant of research privilege not affected by (b)(2)(C) order.* The issuance of an order under subsection (b)(2)(C) of either of the sections authorizing this part (21 U.S.C. 1175 and 42 U.S.C. 4582) in no way affects the continuing effectiveness of any exercise of the authority of the Secretary of Health, Education, and Welfare under 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) or the Attorney General under section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c)).

§ 2.24–1 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act.—Basis and purpose.

(a) In Pub. L. 93–282, the Congress expressly amended (by sections 122(a) and 303(a), 88 Stat. 131 and 137) the provisions of law which authorize this part, expressly amended (by section 122(b), 88 Stat. 132) the research privilege section under the Secretary's jurisdiction, and made explicit reference (in section 303(d), 88 Stat. 139) to the regulations previously issued by the Special Action Office for Drug Abuse Prevention reconciling the provisions of section 408 of the Drug Abuse Office and Treatment Act of 1972 with the provisions of the research privilege sections. When the bill which became Pub. L. 93–282 was before the House of Representatives for its last Congressional consideration before transmission to the President, its floor manager, Chairman Staggers of the Committee on Interstate and Foreign Commerce, inserted in the Record a detailed analysis of the bill in its final form (Congressional Record, daily edition, May 6, 1974, page H3563). This analysis contained the following paragraph:

> The relationship of section 303(a) of the Public Health Service Act, authorizing the administrative grant of absolute confidentiality for research, to section 408 of the Drug Abuse Office and Treatment Act of 1972, requiring that Federally-connected drug abuse patient records generally be kept confidential, has been correctly described in an interpretative regulation, 21 C.F.R. 1401.61 and 1401.62, which was upheld in *People v. Newman*, 32 N.Y. 2d 379, [reversing] 336 N.Y.S. 2d 127, 298 N.E. 2d 651 (1973); *certiorari* denied, [414] U.S. [1163], 94 S. Ct. 927, [39 L. Ed. 2d 116] (1974). For that reason, among others, section 303(d) of the Senate amendment expressly continues the effectiveness of the current regulation promulgated by the Director of the Special Action Office for Drug Abuse Prevention. Thus, although section 502(c) of the Comprehensive Drug Abuse Prevention and Control Act of 1970 is not explicitly referred to in this legislation, the congressional intent is clear that the authority conferred by that section was not modified by Pub. L. 92–255, and is not intended to be modified by the bill now before the House.

(b) Sections 2.24 and 2.61 restate, in substance, the interpretative rules (§§ 1401.61 and 1401.62 of the previous regulations) referred to in the passage quoted in paragraph (a) of this section, modified to reflect the amendment made to section 303(a) of the Public Health Service Act (42 U.S.C. 242(a)) by Pub. L. 93–282.

Subpart C—Disclosures With Patient's Consent

§ 2.31 Written consent required.—Rules.

(a) *Form of consent.* Except as otherwise provided, a consent for a disclosure under this part must be in writing and must contain the following:

(1) The name of the program which is to make the disclosure.

(2) The name or title of the person or organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose or need for the disclosure.

(5) The extent or nature of information to be disclosed.

(6) A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and a specification of the date, event, or condition upon which it will expire without express revocation.

(7) The date on which the consent is signed.

(8) The signature of the patient and, when required under § 2.15, the signature of a person authorized to give consent under that section; or, when required under § 2.16, the signature of a person authorized to sign under that section in lieu of the patient.

(b) *Duration of consent.* Any consent given under this subpart shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

(c) *Disclosure prohibited with deficient consent.* No program may disclose any information on the basis of a consent form—

(1) which on its face substantially fails to conform to any of the requirements set forth in paragraph (a), of this section, or

(2) which is known, or in the exercise of reasonable care should be known, to the responsible personnel of the program to be materially false in respect to any item required to be contained therein pursuant to paragraph (a) of this section.

(d) *Falsification prohibited.* No person may knowingly make, sign, or furnish to a program any consent form which is materially false with respect to any item required to be contained therein pursuant to paragraph (a) of this section.

§ 2.31–1 Written consent required.—Basis and purpose.

(a) The use of a consent form containing all of the elements specified in § 2.31(a) is necessary to assure compliance with the requirements of this subpart. Under § 1401.21 of the previous regulations, a much more abbreviated form was permissible, because the circumstances under which any consent could be given were very strictly limited. Now that the authorizing legislation permits disclosure with consent "to such extent, under such circumstances, and for such purposes as may be allowed under regulations," the consent form should show on its face information sufficient to indicate compliance with the regulations.

(b) Sections 2.31(b), 2.31(c), and 2.31(d) are an exercise of the general rulemaking authority in subsection (g) of the authorizing legislation. Section 2.31(c) imposes a legal liability on programs and their personnel for disclosure of information on the basis of a materially deficient consent, and § 2.31(d) imposes liability on any person who submits a falsified consent form to a program.

§ 2.32 Prohibition on redisclosure.—Rules.

(a) *Notice to accompany disclosure.* Whenever a written disclosure is made under authority of this subpart, except a disclosure to a program or other person whose records pertaining to the patient are otherwise subject to this part, the disclosure shall be accompanied by a written statement substantially as follows: "This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose." An oral disclosure may be accompanied or followed by such a notice.

(b) *Consent required for redisclosure.* A person who receives information from patient records and has been notified substantially in accordance with paragraph (a) of this section is prohibited from making any disclosure of such information except with the specific written consent of the person to whom it pertains, or as otherwise permitted under this part.

(c) *Restriction on redisclosure.* Whenever information from patient records is needed by any person, such information must be obtained directly from the program maintaining such records and not from another person to whom disclosure thereof has been made, except where the initial disclosure was intentionally and expressly made for the purpose of redisclosure (as for example in the case of an employment agency), or the information is no longer available from the program and redisclosure is not prohibited by any other provision of this part.

§ 2.32–1 Prohibition on redisclosure.—Basis and purpose.

(a) Section 2.32 is intended to provide a reasonable protection against redisclosure of information disclosed with consent in accordance with this subpart. There is, of course, no problem where the information becomes part of a record which is itself subject to this part because it is maintained in connection with the performance of a covered substance abuse prevention function. The difficulty arises when the disclosure is made to those whose records are not otherwise affected by this part. To attempt to make all of the provisions of this part applicable to such recipients with respect to such information might raise serious problems of legality, administrative feasibility, and fairness, but where they are given actual notice that specific patient consent is normally required for redisclosure, we think they can and should be bound by it.

(b) Oral disclosures are not mandatorily covered because they should rarely be made to any recipient with whom the program does not have a continuing relationship. Where such a relationship exists or the program is otherwise satisfied that the recipient understands and will respect the confidential nature of the information supplied, there seems no need to add to the already heavy load of paperwork with which programs must contend.

§ 2.33 Diagnosis, treatment, and rehabilitation.—Rules.

(a) *Disclosure authorized.* Where consent is given in accordance with § 2.31, disclosure of information subject to this part may be made to medical personnel or to treatment or rehabilitation programs where such disclosure is needed in order to better enable them to furnish services to the patient to whom the information pertains.

(b) *Traveling, incarcerated, or hospitalized patients on medication.* Where a patent on medication is at a distance from his normal residence or treatment program or is incarcerated or hospitalized, or is otherwise unable to deliver a written consent to his treatment program at the time the disclosure is needed, confirmation of the patient's status and information necessary to appropriately continue or modify his medication may be given to medical personnel in a position to provide services to the patient upon the oral representation of such personnel that the patient has requested medication and consented to such disclosure. Any program making a disclosure in accordance with this paragraph shall make a written memorandum showing the name of the patient, or the patient's case number assigned by the program, the date and time the disclosure was made, the information disclosed, and the names of the individuals by whom and to whom it was made.

§ 2.33–1 Diagnosis, treatment, and rehabilitation.—Basis and purpose.

(a) Section 2.33(a) is a restatement of the policy set forth in § 1401.22(a) of the previous regulations, expanded to make explicit reference to nonmedical counselling and other treatment and rehabilitative services.

(b) Section 2.33(b) clarifies the corresponding provision in § 1401.22(a) of the previous regulations by specifying how and through whom oral consent can be given, and limiting the disclosure to that necessary to determine appropriate medication.

§ 2.34 Prevention of certain multiple enrollments.—Rules.

(a) *Definitions.* For the purposes of this section and § 2.55—

(1) The terms "administer", "controlled substance", "dispense", "maintenance treatment", and "detoxification treatment" shall respectively have the meanings defined in paragraphs (2), (6), (10), (27), and (28) of section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) The term "program" means a program which offers maintenance treatment or detoxification treatment.

(3) The term "permissible central registry" means a qualified service organization which collects or accepts, from two or more programs (referred to hereinafter as member programs) all of which are located either within a given State or not more than 125 miles from the nearest point on the border of such State, patient identifying information about persons applying for maintenance treatment or detoxification treatment for the purpose of enabling the member programs to prevent any individual from being concurrently enrolled in more than one such program.

(b) *Use of central registries prohibited except as expressly authorized.* The furnishing of patient identifying information by a program to any central registry which fails to meet the definition of a permissible central registry set forth in paragraph (a)(3) of this section is prohibited, and the furnishing of patient identifying information to or by any central registry except as authorized in this section is prohibited. Information pertaining to patients held by a central registry may be furnished or used in accordance with paragraphs (e), (f), and (g) for the purpose of preventing multiple enrollments, but may not be otherwise furnished or used in connection with any legal, administrative, supervisory, or other action with respect to any patient.

(c) *Safeguards and procedures required.* To minimize the likelihood of disclosures of information to impostors or others seeking to bring about unauthorized or improper disclosure, any communications carried on by programs pursuant to this section must be conducted (1) by authorized personnel designated in accordance with § 2.17(b), and (2) in conformity with procedures established in accordance with that section.

(d) *Disclosures with respect to patients in treatment.* A member program may supply patient identifying information and information concerning the type of drug used or to be used in treatment and the dosage thereof, with relevant dates, to a permissible central registry with respect to any patient—

(1) When the patient is accepted for treatment,

(2) When the type or dosage of the drug is changed, and

(3) When the treatment is interrupted, resumed, or terminated.

(e) *Disclosures with respect to applications.* When any person applies to a program for maintenance treatment or detoxification treatment, then for the purpose of inquiring whether such person is currently enrolled in another program for such treatment, the program may furnish patient identifying information with respect to such person—

(1) To any permissible central registry of which the program is a member, and

(2) To any other program which is not more than 200 miles distant and which is not a member of any central registry of which the inquiring program is a member.

(f) *Program procedure in case of apparent concurrent enrollment.* When an inquiry pursuant to paragraph (e)(2) is made of another treatment program and its response is affirmative, the two programs may engage in such further communication as may be necessary to establish whether an error has been made, and if none, the programs should proceed in accordance with sound clinical practice and any applicable regulations pertaining to the type of treatment involved.

(g) *Registry procedure in case of apparent concurrent enrollment.* When an inquiry pursuant to paragraph (e)(1) is made of a permissible central registry and its response is affirmative, it may advise the inquiring program of the name, address, and telephone number of the other program, or it may advise the other program of the identity of the patient and the name, address, and telephone number of the inquiring program, or it may do both, and in any case the two programs may then communicate as provided in paragraph (f) above.

(h) *Advice to patients.* When the policies and procedures of any program involve any disclosures pursuant to this section, before any patient is accepted for or continued in treatment (other than detoxification treatment) after September 30, 1975, written consent in accordance with § 2.31 shall be obtained. Such consent shall set forth a current list of the names and addresses either of any programs or of any central registries to which such disclosures will be made. Notwithstanding the requirement of § 2.31 (a)(2), such consent shall be effective with respect to any other such program thereafter established within 200 miles, or any registry serving such programs, and shall so state. Such consent shall be effective for as long as the patient remains enrolled in the program to which it is given.

§ 2.34–1 Prevention of certain multiple enrollments.—Basis and purpose.

Section 2.34 is based upon § 1401.43 of the previous regulations. It was omitted from the August 22, 1974 draft, but comments on the omission made it clear that in certain areas of the country, central registries are a functional component of the treatment system, and that regulations to guide their operations are needed.

§ 2.35 Legal counsel for patient.—Rules.

When a bona fide attorney-client relationship exists between an attorney-at-law and a patient, disclosure of any information in the patient's records may be made to the attorney upon the written application of the patient endorsed by the attorney. Information so disclosed may not be further disclosed by the attorney.

§ 2.35–1 Legal counsel for patient.—Basis and purpose.

Section 2.35 simplifies and broadens the statement of the policy embodied in § 1401.25 of the previous regulations. Its purpose is to assure the availability to the attorney, with his client's consent, of any information needed as a basis for advice and counsel. The purpose of the prohibition on further disclosure by the attorney is to guard against the possibility that the attorney might be forced to serve as a conduit for otherwise prohibited disclosures to third parties. Ordinarily, the attorney-client privilege would suffice, but that privilege is subject to waiver by the client, whereas this prohibition is not. Where there is a need for disclosure to a third party of any given information about any patient, this prohibition in no way affects the availability of other sections of this part to authorize such disclosure by the program.

§ 2.36 Patient's family and others.—Rule.

Where consent is given in accordance with § 2.31, information evaluating his current or past status in a treatment program may be furnished to any person with whom the patient has a personal relationship unless, in the judgment of the person responsible for the patient's treatment, the disclosure of such information would be harmful to the patient.

§ 2.36–1 Patient's family and others.—Basis and purpose.

Section 2.36 expresses the same policy as was embodied in § 1401.27 of the previous regulations, broadened to reflect the expanded authority for consensual disclosure under the authorizing legislation.

§ 2.37 Third-party payers and funding sources.—Rules.

(a) *Acquisition of information.* Disclosure of patient information to third-party payers or funding sources may be made only with the written consent of the patient given in accordance with § 2.31 and any such disclosure must be limited to that information which is reasonably necessary for the discharge of the legal or contractual obligations of the third-party payer or funding source.

(b) *Prohibition on disclosure.* Where a funding source or third-party payer maintains records of the identity of recipients of treatment or rehabilitation services for alcohol or drug abuse such records are, under the authorizing legislation, maintained in connection with the performance of an alcohol or drug abuse prevention function and are subject to the restrictions upon disclosure set forth in this part.

§ 2.37–1 Third-party payers and funding sources.—Basis and purpose.

Section 2.37 is based upon the general authority to prescribe regulations to carry out the purposes of the authorizing legislation. The great diversity of contractual arrangements and legal requirements under which the operations of third-party payers and funding sources are carried on precludes the prescription of detailed records management instructions in these regulations, even if that were otherwise desirable. The general principles set forth in § 2.37, however, should clarify the question of coverage, and where coverage exists, provide a standard which will minimize the likelihood of violations. See also § 2.12–1(g).

§ 2.38 Employers and employment agencies.—Rules.

(a) *Disclosure permitted.* Where consent is given in accordance with § 2.31, a program may make disclosures in accordance with this section.

(b) *Eligible recipients.* A program may make disclosures under this section to public or private employment agencies, employment services, or employers.

(c) *Scope of disclosure.* Ordinarily, disclosures pursuant to this section should be limited to a verification of the patient's status in treatment or a general evaluation of progress in treatment. More specific information may be furnished where there is a bona fide need for such information to evaluate hazards which the employment may pose to the patient or others, or where such information is otherwise directly relevant to the employment situation.

(d) *Criteria for approval.* A disclosure under this section may be made if, in the judgment of the program director or his authorized representative appointed as provided in § 2.17(b), the following criteria are met:

(1) The program has reason to believe, on the basis of past experience or other credible information (which may in appropriate cases consist of a written statement by the employer), that such information will be used for the purpose of assisting in the rehabilitation of the patient and not for the purpose of identifying the individual as a patient in order to deny him employment or advancement because of his history of drug or alcohol abuse.

(2) The information sought appears to be reasonably necessary in view of the type of employment involved.

§ 2.38–1 Employers and employment agencies.—Basis and purpose.

Section 2.38 is based on the rulemaking power conferred by subsection (b)(1) of the authorizing legislation, and is adapted from § 1401.26 of the previous regulations. Its purpose is to allow disclosures reasonably necessary and appropriate to facilitate the employment of patients and former patients, while protecting patients against unnecessary or excessively broad disclosures. It was urged in a comment received on the August 22, 1974 draft that disclosures to employers be flatly prohibited on the ground that the employer's sole legitimate concern is with on-the-job performance. While we are not unsympathetic to this view, a countervailing consideration is that in the case of an employee or applicant who is known by the employer to have a problem with drugs or alcohol, knowledge by the employer of a genuine effort by the employee to deal with it can make the difference between a job and no job.

§ 2.39 Criminal justice system referrals.—Rules.

(a) *Consent authorized.* Where participation by an individual in a treatment program is made a condition of such individual's release from confinement, the disposition or status of any criminal proceedings against him or the execution or suspension of any sentence imposed upon him, such individual may consent to unrestricted communication between any program in which he is enrolled in fulfillment of such condition and (1) the court granting probation, or other post-trial or pretrial conditional release, (2) the parole board or other authority granting parole, or (3) probation or parole officers responsible for his supervision.

(b) *Duration of consent.* Where consent is given for disclosures described in paragraph (a) of this section, such consent shall expire sixty days after it is given or when there is a substantial change in such person's status, whichever is later. For the purposes of this section, a substantial change occurs in the status of a person who, at the time such consent is given, has been—

(1) Arrested, when such person is formally charged or unconditionally released from arrest;

(2) Formally charged, when the charges have been dismissed with prejudice, or the trial of such person has been commenced;

(3) Brought to a trial which has commenced, when such person has been acquitted or sentenced;

(4) Sentenced, when the sentence has been fully executed.

(c) *Revocation of consent.* An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and effective termination or revocation of such release from confinement, probation, or parole.

(d) *Restrictions on redisclosure.* Any information directly or indirectly received pursuant to this section may be used by the recipients thereof only in connection with their official duties with respect to the particular individual with respect to whom it was acquired. Such recipients may not make such information available for general investigative purposes, or otherwise use it in unrelated proceedings or make it available for unrelated purposes.

§ 2.39–1 Criminal justice system referrals.—Basis and purpose.

(a) On the basis of extensive written comment and oral communications received on the subject matter of § 2.39 as proposed in the May 9, 1975 notice (designated as § 2.40 in that notice), we have concluded that the latitude allowed and the conditions imposed in § 2.39 as set forth above are necessary and proper to effectuate the purposes of the authorizing legislation.

(b) From a legal standpoint, it seems highly doubtful whether, in a proceeding to revoke probation or parole, the due process requirements laid down in *Morrissey v. Brewer*, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed.2d 484 (1972) and *Gagnon v. Scarpelli*, 411 U.S. 778, 93 S.Ct. 1756, 36 L.Ed.2d 636 (1973) could be met by an unsupported general evaluation by a treatment program to the effect that a patient's status or progress in treatment was unsatisfactory. Thus, if such an evaluation were all that could be communicated by a program about a particular patient's conduct during the period he was in treatment, a condition requiring satisfactory participation in a treatment program would to all intents and purposes become unenforceable. Moreover, if it were held to be enforceable, the operative decision on the revocation issue would then be made by the program, arguably exacerbating rather than alleviating its role-conflict problem. It may thus be the part of wisdom to confess that some degree of role-conflict is inherent in the situation of any program which accepts criminal justice referrals. If so, the issue then becomes that of finding the most constructive way to handle the conflict, rather than a sterile and futile effort to avoid it altogether.

(c) We are persuaded that in many instances a prohibition on free communication between probation officers and drug abuse program counsellors would have profoundly deleterious effects on the rehabilitative process. Many probation officers bring to their work a high degree of training, professionalism, and experience. They are under no illusion that they are dealing with a clientelle which will never stumble or relapse, and if they have the information necessary to intervene at an early stage of such an episode, their intervention can often make the difference between success and failure for the client.

(d) There is, however, nothing in these regulations which precludes treatment programs from entering into agreements or arrangements with agencies or institutions of the criminal justice system to regulate or restrict the subject matter or form of communications of information about patients. For example, such an arrangement might provide for free oral communication between counsellors and probation officers, while restricting formal written reports by the program to specified types of so-called hard data such as attendance and urinalysis results. In view of widely differing conditions and attitudes in various parts of the country, substantial variations in such arrangements are not only expectable but desirable.

(e) A further aspect of this matter, which was not adequately considered or dealt with in the May 9 proposal, is the impact which the rules laid down in § 2.39 have on the bail decision. There is a high correlation between the disposition of the application for bail and the type of sentence which may be meted out upon conviction. The contrast between the recidivism rates for those who receive treatment and supervision, as against those who simply receive the punishment of incarceration, is a powerful argument against restrictions which would tend to narrow the circumstances under which conscientious judges can grant bail.

(f) It must be emphasized that § 2.39 in no way reduces the necessity to obtain written consent from patients, whether or not referred by the criminal justice system, before disclosures for the purposes here involved can be made by programs. We have been urged to make an exception from the requirement of § 2.31 in the case of parolees and probationers, but such an exception would be wholly unsupported by the authorizing legislation. In fashioning these regulations, it is not our privilege to adorn a tabula rasa according to our own predilections: rather, it is our duty to interlineate a statute with fidelity to its spirit, its terms, and its purposes.

§ 2.40 Situations not otherwise provided for.—Rules.

(a) *Criteria for approval.* In any situation not otherwise specifically provided for in this subpart, where consent is given in accordance with § 2.31, a program may make a disclosure for the benefit of a patient from the records of that patient if, in the judgment of the program director or his authorized representative appointed as provided in § 2.17, all of the following criteria are met:

(1) There is no suggestion in the written consent or the circumstances surrounding it, as known to the program, that the consent was not given freely, voluntarily, and without coercion.

(2) Granting the request for disclosure will not cause substantial harm to the relationship between the patient and the program or to the program's capacity to provide services in general.

(3) Granting the request for disclosure will not be harmful to the patient.

(b) *Circumstances deemed beneficial.* For the purposes of this section, the circumstances under which disclosure may be deemed to be beneficial to a patient include, but are not limited to, those in which the disclosure may assist the patient in connection with any public or private claim, right, privilege, gratuity, grant or other interest accruing to, or for the benefit of, the patient or the patient's immediate family. Examples of the foregoing include welfare, medicare, unemployment, workmen's compensation, accident or medical insurance, public or private pension or other retirement benefits, and any claim or defense asserted or which is an issue in any civil, criminal, administrative or other proceeding in which the patient is a party or is affected.

§ 2.40–1 Situations not otherwise provided for.—Basis and purpose.

(a) Section 2.40 is based upon § 1401.23 of the previous regulations, amended to reflect the expansion made by the change in the law with respect to the permissible scope of consensual disclosures.

(b) A strong case can be made for the proposition that § 2.40 should, in effect if not expressly, require a program to make any disclosure requested by a patient. The discretion vested in the program, it can be argued, is at best an expression of overprotective paternalism, and at worst, an invitation to programs to cover up material potentially embarrassing to themselves. Bearing in mind, however, that persons who have obtained the type of treatment to which this part applies are more vulnerable to pressures of various kinds than are patients in general, it seems preferable to retain some responsibility on the part of the program to protect the best interests of its patients in this very sensitive area. This, like many other choices which these regulations reflect, is a determination which can be reviewed and revised from time to time in the light of experience.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.—Rules.

(a) *In general.* Disclosure to medical personnel, either private or governmental, is authorized without the consent of the patient when and to the extent necessary to meet a bona fide medical emergency.

(b) *Food and Drug Administration.* Where treatment involves the use of any drug, and appropriate officials of the Food and Drug Administration determine that the life or health of patients may be endangered by an error in the manufacture or packaging of such drug, disclosure of the identities of the recipients of the drug may be made without their consent to appropriate officials of the Food and Drug Administration to enable them to notify the patients or their physicians of the problem in order that corrective action may be taken.

(c) *Incapacitated persons.* Where a patient is incapacitated and information concerning the treatment being given him by a program is necessary to make a sound determination of appropriate emergency treatment, such information may be given without the patient's consent to personnel providing such emergency treatment.

(d) *Notification of family or others.* When any individual suffering from a serious medical condition resulting from drug or alcohol abuse is receiving treatment at a facility which is within the scope of this Part the treating physician may, in his discretion, give notification of such condition to a member of the individual's family or any other person with whom the individual is known to have a responsible personal relationship. Such notification may not be made without such individual's consent at any time such individual is capable of rational communication.

(e) *Record required.* Any program making an oral disclosure under authority of this section shall make a written memorandum showing the patient's name or case number, the date and time the disclosure was made, some indication of the nature of the emergency, the information disclosed, and the names of the individuals by whom and to whom it was disclosed.

§ 2.51–1 Medical emergencies.—Basis and purpose.

The provisions of § 2.51 are adapted from § 1401.42 of the previous regulations, and are based on subsection (b)(2)(A) of the authorizing legislation. The provision in the previous regulations with respect to patients who may be incarcerated is now covered in § 2.33(b).

Paragraph (d) of § 2.51 is based upon the theory that the disclosure there allowed is of the patient's endangered condition, not his identity as a drug or alcohol abuse patient, and that the humanitarian necessity of such notification outweighs its potential for accidental violation of confidentiality

§ 2.52 Research, audit, and evaluation.—Rules.

(a) *Research, audit, and evaluation.* Subject to any applicable specific provision set forth hereinafter in this subpart, the content of records pertaining to any patient which are maintained in connection with the performance of a function subject to this part may be disclosed, whether or not the patient gives consent, to qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner. For the purposes of this subpart and for the purposes of subsection (b)(2)(B) of the authorizing legislation, the term "qualified personnel" means persons whose training and experience are appropriate to the nature and level of the work in which they are engaged and who, when working as part of an organization, are performing such work with adequate administrative safeguards against unauthorized disclosures.

(b) *Use of disclosures of patient identifying information.*

(1) Where a disclosure made to any person pursuant to paragraph (a) of this section includes patient identifying information with respect to any patient, such information may not be further disclosed, and may not be used in connection with any legal, administrative, supervisory, or other action whatsoever with respect to such patient, except as provided in paragraphs (b)(2) and (b)(3) of this section.

(2) The inclusion of patient identifying information in any written or oral communication between a person to whom a disclosure has been made pursuant to paragraph (a) and the program making such disclosure does not constitute the identification of a patient in a report or otherwise in violation of paragraph (a).

(3) Where a disclosure is made pursuant to paragraph (a) of this section to a person qualified to determine, on the basis of such disclosure, the presence of a substantial risk to the health and well being, whether physical or psychological, of any patient, and, in the judgment of such person, such a risk exists and the situation cannot be dealt with solely by means of communications as described in paragraph (b)(2) of this section without intensifying or prolonging the risk as compared with other means of dealing with it, then the initial disclosure under paragraph (a) and any subsequent disclosure or redisclosure of patient identifying information for the purpose of reducing the risk to the patient involved shall be subject to the provisions of § 2.51.

§ 2.52–1 Research, audit, and evaluation.—Basis and purpose.

(a) *General purpose.* Subsection (a) of this section is adapted directly from subsection (b)(2)(B) of the authorizing legislation. The purpose of each is the same: To facilitate the search for truth, whether in the context of scientific investigation, administrative management, or broad issues of public policy, while at the same time safeguarding the personal privacy of the individuals who are the intended beneficiaries of the process or program under investigation. This subpart in particular, and this part as a whole, are intended to aid in carrying out that purpose.

(b) The succeeding sections of this subpart deal with problems which arise in connection with disclosures made for certain specific purposes which have been interpreted as falling within the general purposes embraced by § 2.52. Those sections will be best understood, however, in the light of some discussion of the underlying premises of the general rule, and its relationship to two other legal concepts: the right of privacy, and the duty to obtain informed consent from research subjects.

(c) *The Right of Privacy.* So far as is relevant to this discussion, we may consider the right of privacy in two aspects. One, a protection against improper governmental activity, is the right to be secure against unreasonable searches and seizures guaranteed by the Fourth Amendment, with some expansion from the penumbras of the Fifth and Sixth Amendments. The protections afforded to patients by the authorizing legislation, not to mention these regulations, go far beyond those which are constitutionally required.

(d) The other aspect of the right of privacy, which has sometimes been described as the right to be left alone, is the notion that an individual has a right not to be hurt by intrusions into his essentially personal concerns, or to have essentially private information exploited for commercial gain, whether or not the intrusion or exploitation is in connection with any possible governmental action against him. The courts have spoken of a right of privacy in a wide variety of contexts, but they have repeatedly and explicitly rejected the notion that anyone has a right to go about his daily affairs encapsulated in an impenetrable bubble of anonymity. The courts have been careful to weigh the competing interests, and the social interest in valid research and evaluation is clearly of sufficient moment to be considered in this process.

(e) In defense of the position that disclosure of patient identifying information even for carefully guarded scientific research should be permitted only on a consensual basis, two dominant lines of argument, somewhat interrelated, have emerged. One is that retrospective

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studies are of questionable value in any case, and the other is that a sampling technique involving informed consent on the part of the members of the sample can always be used to develop the information sought. Neither line of argument will withstand careful scrutiny.

(f) It is true, of course, that the efficacy of a given therapeutic agent can often best be evaluated by means of a well-designed prospective study in which special recordkeeping procedures, special criteria for patient selection, and an appropriate control have all been established with a view to the purpose of the study. There are, however, many important investigations which simply do not lend themselves to such a format. Sometimes the desirability or even the possibility of a particular study does not suggest itself except in retrospect. Another important consideration is the fact that knowledge that an investigation is going on may influence the behavior of patients, clinicians, or both. Where such knowledge can influence the make-up of a sample, it will normally do so in the direction of favorable outcomes, but to an unknown degree, thus tending to invalidate the results reported.

(g) While the sample technique has its uses, especially with populations that are unmanageably large, it is often less difficult and expensive, and less likely to interfere with the actual conduct and outcomes of treatment or rehabilitation processes, to use the full population under study. Even more important than economy and administrative convenience in carrying out a study, there may be an overriding advantage in terms of eliminating any question as to the validity of the results of the study on the ground of bias in the selection of the sample.

(h) *Informed Consent.* The duty to obtain informed consent is obvious and compelling in situations where an individual is exposed to the possibility of harm, either physical or psychological, as a consequence of medical procedures, research, or similar activities. Where such a situation exists the person conducting the research or medical procedure violates his duty to the subject or patient if he proceeds without obtaining the voluntary informed consent from the individual or his legally authorized representative. Thus, in conducting an activity which places the subject or patient at risk the practitioner may not give precedence to a hidden agenda, even for so lofty a motive as the advancement of knowledge. In this regard, see the Department of Health, Education and Welfare's Protection of Human Subjects Regulations, 45 CFR Part 46. Those regulations are applicable to all Department of Health, Education and Welfare grants and contracts supporting research, development and related activities involving human subjects.

(i) It is apparent that the foregoing rationale for requiring informed consent does not apply to the same degree in situations involving the disclosure of clinical records for research in the form of follow-up or retrospective studies. Under these circumstances the risk to the subject is that some disclosure or misuse of information from which he could be identified might result in embarrassment, lost opportunities, or other forms of psychological or social injury. While that possibility of harm could be reduced by requiring consent to every review of clinical records for research purposes, a similar result can be achieved by the less restrictive method of limiting further disclosure of identifying information by the researcher. Given the applicability of this alternative, equally effective means for protecting a patient or subject from the possibility of a harmful public disclosure, it is unreasonable to insist upon informed consent to every review of clinical records for the purposes of conducting legitimate research, particularly since such insistence could lead to the ultimate absurdity of prohibiting efforts to identify the nature and source of an unknown plague simply because the patients or researcher lacked the clairvoyance to have consent forms signed prior to the onset of the affliction.

(j) In sum, there are restraints on certain means of governmental acquisition of information about individuals which are operative irrespective of how the information is used, and there are restraints on the uses of information which are independent of how or by whom it is acquired, but they do not and should not add up to the proposition that the use of information about a person is either morally or legally the absolute prerogative of that person to determine.

(k) For all of these reasons, the authorizing legislation expressly provides that patient consent is not required with respect to disclosures for research, audit, and evaluation, nor does it prohibit individual patient identification in connection with such disclosures. While it is entirely appropriate to impose safeguards and procedures in connection with these activities, it would be wholly inappropriate to use the rulemaking process to impose an absolute requirement of patient consent with respect to activities which by statute may be conducted without it.

(l) *Classification of activities.* It is clear that Congress intended a balancing of the social interest in the validity of the results of inquiry, on the one hand, with the individual interest in anonymity, on the other, all within the limits set by the legislation and the constitution. With that objective in mind, we may now turn to the various categories of activities which come within the purview of this subpart.

(m) These activities may be classified first, in regard to whether participation is voluntary from the standpoint of the program, and second, as to whether the objective is to ascertain compliance with predetermined standards (examinations as defined in § 2.54, and program evaluation as defined in § 2.11(g)(1)), or to ascertain the validity of a given standard or hypothesis (scientific research, and program evaluation as defined in § 2.11(g)(2)). The application of the foregoing classifications logically results in the creation of four categories of activities. Three of them are specifically dealt with in the succeeding sections of this subpart and need not detain us here; the fourth is discussed below.

(n) *Scientific research and evaluation.* Beyond the bare restatement of the authorizing legislation set forth in § 2.52, these regulations are deliberately silent with respect to purely voluntary scientific research and program evaluation in the sense defined in § 2.11(g)(2). Testimony and written comments received on the August 22, 1974 draft regulations were noteworthy in two respects. First, no instances of abuse on the part of persons acquiring patient identifying information under these circumstances were cited. Second, while there was some well-founded criticism of the attempt in that draft to provide guidelines for determining what is scientific research and who is qualified to do it, no usable alternatives—indeed, almost no alternatives at all—were forthcoming.

(o) In one of the written comments, the writer cautioned against any assumption "that our major remaining problems in drug and alcohol abuse treatment are prevention of illicit diversion and protection of confidentiality," and suggested "that we still have a problem in discovering, testing and evaluating improved treatment techniques. To do this," he continued, "one should place minimal obstacles in the way of bona fide clinical and epidemiologic research!"

(p) The result of leaving the rule as it is in the statute, without attempting to sharpen its outlines or define its terms, will be to leave it for interpretation on a case-by-case basis by those who must apply it in practice: the researchers who seek the information, and the programs which supply it. This does not foreclose the possibility of amending the regulations on the basis of experience if it appears either that clinicians are becoming so cautious that research and evaluation studies are being choked off, or that abuses are occurring in the use of information disclosed. But until a need for more detailed regulation in this area is demonstrated, we think its imposition would do more harm than good.

§ 2.53 Governmental agencies.—Rules.

(a) *In general.* Where research, audit, or evaluation functions are performed by or on behalf of a State or Federal governmental agency, the minimum qualifications of personnel performing such functions may be determined by such agency, subject to the provisions of this part, with particular reference to the organizational requirements and limitations on the categories of records subject to review by different categories of personnel.

(b) *Financial and administrative records.* Where program records are reviewed by personnel who lack either the responsibility for, or appropriate training and supervision for, conducting scientific research, determining adherence to treatment standards, or evaluating treatment as such, such review should be confined as far as practicable to administrative and financial records. Under no circumstances should such personnel be shown caseworker or counsellor notes, or similar clinical records. Programs should organize their records so that financial and administrative matters can be reviewed without disclosing clinical information and without disclosing patient identifying information except where necessary for audit verification.

(c) *Scientific research and long-term evaluation studies.* No State and no agency or political subdivision of a State may require, as a condition to funding, licensing, or otherwise, that any program furnish patient identifying information for the purpose of conducting scientific research or long-term evaluation studies unless the recipient of such information is legally required to hold such information in confidence, is prohibited from taking any administrative, investigative, or other action with respect to any individual patient on the basis of such information, and is prohibited from identifying, directly or indirectly, any individual patient in any report of such research or evaluation, or otherwise disclosing patient identities in any manner.

(d) *Opinion and description to be furnished program.* Before any patient identifying information is required to be submitted by a program under the circumstances described in paragraph (c), the program shall be furnished—

(1) An opinion by the attorney general or other chief legal officer of the State to the effect that the conditions specified in paragraph (c) are fulfilled with respect to such program or with respect to all programs in such State similarly situated, and

(2) A description of the administrative procedures and physical limitations on access or other measures to provide for the security of the data, but such description shall not be in such detail as to furnish guidance for wrongful attempts to breach such security.

(e) *Exclusiveness of procedures.* No State or local governmental agency may require any treatment program to furnish patient identifying information to itself or any other recipient except in conformity with this section or § 2.54. No Federal agency may require any treatment program to furnish patient identifying information to itself or any other recipient except in conformity with this section (other than paragraph (d)(1) thereof) or § 2.54.

§ 2.53–1 Governmental agencies.—Basis and purpose.

Section 2.53 is an implementation of the authority contained in subsection (g) of the authorizing legislation to provide safeguards and procedures to effectuate the purposes of such legislation. It makes clear that whenever information is required of a program, whether by law or by the terms or conditions of a contract or grant, the procedures and safeguards required under this section are applicable.

§ 2.54 Patient identifying information in connection with examinations.—Rules.

(a) *Definitions.* For the purposes of this section—

(1) The term "examination" means any examination to which this section is made applicable by paragraph (b) of this section.

(2) The term "examiner" means any individual or any public or private organization, including any Federal, State, or local governmental agency, which conducts an examination to which this section applies.

(b) *Applicability.* This section applies to any examination of the records of a treatment program which is carried out for the purpose of or as aid to ascertaining the accuracy or adequacy of its financial or other records, or the efficiency or effectiveness of its financial, administrative, or medical management, or its adherence to financial, legal, medical, administrative, or other standards, regardless of whether such examination is called an audit, an evaluation, an inspection, or by any other name.

(c) *Statement required for disclosure of patient identifying information in connection with examination.* No program may make, and no examiner may require, any disclosure of patient identifying information in connection with an examination unless the examiner furnishes to the program a written statement—

(1) that no record of patient identifying information will be made or retained by or on behalf of the examiner in connection with the examination without notice to the program in accordance with paragraph (c)(2) of this section, or

(2) setting forth the specific purpose for which a record of patient identifying information is being retained by or on behalf of the examiner, the location at which such information will be kept, and the name, official title, address, and telephone number of a responsible individual to whom any inquiries by the program about the disposition of such record should be directed.

(d) *Disposition of record of patient identifying information in connection with examination.* After any record of patient identifying information retained in connection with an examination has served its purpose, or within the time prescribed in paragraph (e) of this section, whichever is earlier, the examiner shall destroy or return to the program all records (including any copies thereof) containing patient indentifying information which have been in its possession in connection with such examination.

(e) *Maximum time allowed for disposition.* The action required by paragraph (d) shall be completed—

(1) Except as provided in paragraph (e)(2) of this section not more than two years after the record was acquired by or on behalf of the examiner, or

(2) Where the record is needed in connection with a formal legal proceeding against the program commenced or to be commenced not more than two years after the record was acquired, and written notice to this effect is furnished to the program within two years after the record was acquired, not later than the termination of such proceeding.

(f) *Notice of final disposition.* When an examiner disposes of records as required by paragraph (d) of this section, or not later than the time prescribed by paragraph (e) of this section, whichever is earlier, the examiner shall furnish to the program concerned a written statement—

(1) That there has been compliance with this section and with the provisions of this part prohibiting any disclosure of patient identifying information from records held by auditors or evaluators, or

(2) Specifying the particulars in which there has been a failure of compliance.

§ 2.54–1 Patient identifying information in connection with examinations.—Basis and purpose.

Confidence on the part of treatment program personnel in the integrity of auditing and regulatory processes is important to the effective functioning of the treatment system. It is the purpose of § 2.54 to foster practices which will both justify and engender such confidence.

§ 2.55 Supervision and regulation of narcotic maintenance and detoxification programs.—Rules.

(a) *Definition of "registrant".* For the purposes of this section, the term "registrant" means a person who (1) has pending an application for registration under section 303(g) of the Controlled Substances Act (21 U.S.C. 823(g)), or (2) has been registered under such section and whose registration has not expired or been surrendered or revoked.

(b) *Drug Enforcement Administration.* Duly authorized agents of the Drug Enforcement Administration shall have access to the premises of registrants for the purpose of ascertaining compliance (or ability to comply) with standards established by the Attorney General under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) respecting the security of stocks of narcotic drugs and the maintenance of records (in accordance with section 307 of the Controlled Substances Act, 21 U.S.C. 827) on such drugs. Registrants shall maintain such records separate from and in addition to patients' clinical records required to be maintained under 21 CFR 310.505(d)(7)(iii), which shall not be available to such agents except as authorized under a court order in accordance with Subpart E of this part. Records maintained by registrants for the purposes of section 307 of the Controlled Substances Act (21 U.S.C. 827) need not identify patients by name, address, social security number, or otherwise except by an identifying number assigned by the registrant, but where such a system is used, the registrant shall maintain on a current basis a cross-index referencing each identifying number to the name and address of the patient to whom it refers. Upon request at any time and wtihout advance notice, but subject to the provisions of § 2.54, such agents shall be granted immediate access to any such index. Such agents may use names and addresses so obtained strictly for the purposes of auditing or verifying program records, and shall exercise all reasonable precautions to avoid inadvertent disclosure of patient identities to third parties. Names and other identifying information so obtained may not be compiled or used in any registry or personal data bank of any description.

(c) *Food and Drug Administration.* Duly authorized agents of the Food and Drug Administration shall have access to the premises of registrants and to all records maintained by registrants, for the purpose of ascertaining compliance (or ability to comply) with standards established by the Secretary of Health, Education and Welfare under section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (42 U.S.C. 257a), sections 303(g)(1) and 303(g)(3) of the Controlled Substances Act (21 U.S.C. 823(g)(1) and 823(g)(3)), and sections 505 and 701(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 and 371(a)). When necessary in the conduct of their duties, and subject to the provisions of § 2.54, agents may use names and addresses of patients strictly for the purposes of auditing or verifying program records, and shall exercise all reasonable precautions to avoid inadvertent disclosure of patient identities to third parties. Names and other identifying information on patients obtained pursuant to this section or by any other compulsory process may not be compiled or used in any registry or personal data bank of any description. Except as authorized under this paragraph or by a court order granted under Subpart E of this part, (1) such agents may not, either orally or in writing, except in conversation with personnel of the registrant while on the premises of the registrant, identify any patient otherwise than by reference to an identifying number assigned by the registrant, and (2) such agents may not remove from the premises of the registrant any notes, documents, or copies thereof which contain patient identifying information.

(d) *State drug law enforcement agencies.* Duly authorized agents of any State drug law enforcement agency having jurisdiction and specific responsibility by statute or otherwise for the enforcement of criminal laws relating to controlled substances (as defined in the Controlled Substances Act) shall have access to the premises of any registrant for the purposes (with respect to corresponding provisions, if any, of State law) and subject to the restrictions and limitations set forth in paragraph (b) of this section, and subject to § 2.54.

(e) *State health authorities.*

(1) *Definition of "qualified State health agency".* As used in this paragraph, the term "qualified State health agency" means an agency of State government (i) which has express legal responsibility to ascertain that registrants under its jurisdiction comply with appropriate treatment standards; (ii) which is legally and administratively separate from any agency of State government responsible for investigation of violations of, or enforcement of, criminal law generally or criminal laws relating to controlled substances; (iii) whose personnel are qualified by training or experience to conduct inspections of health care facilities to ascertain compliance with treatment standards; and (iv) whose personnel are by State law, or by published administrative directive enforced by effective sanctions, required to maintain the confidentiality of any information concerning the identity of patients which they may acquire in the course of their official duties.

(2) *Access.* Duly authorized agents of a qualified State health agency shall have access to the premises of registrants and to all records maintained by registrants, for the purpose of ascertaining compliance (or ability to comply) with treatment standards (including those relating to quantities of narcotic drugs which may be provided for unsupervised use by individuals in treatment) established under State law. Such access, and the use of any information thereby obtained, shall be subject to the restrictions and limitations set forth in paragraph (c) of this section, and subject to § 2.54.

§ 2.55–1 Supervision and regulation of narcotic maintenance and detoxification programs.—Basis and purpose.

(a) Section 2.55 is addressed to the general problem described in the following passage from the legislative history of Pub. L. 93–282:

> A major element of the task of fashioning new regulations pursuant to the express rulemaking authority conferred by this legislation will be to reconcile the sometimes conflicting interests of research, audit, and evaluation with rights of privacy and the confidentiality of the relationship between patient and clinician. Such a reconciliation becomes particularly crucial where the functions of research, audit, or evaluation are conducted by a governmental agency with regulatory powers and responsibility, and the treatment involves the use of a drug such as methadone which is in a research status or which is readily susceptible of misuse or illicit diversion.
>
> Because of the difficulty and complexity of the task, the rulemaking authority is intentionally cast in terms broad enough to permit the limitation of the scope, content, or circumstances of any disclosure under subsection (b), whether (b)(1) or (b)(2), in the light of the necessary purposes for which it is made or required. (Congressional Record, daily edition, May 6, 1974, page H3563).

(b) It has been the consistent interpretation of the Special Action Office for Drug Abuse Prevention that the only provision of the authorizing legislation which permits disclosures to compliance officers, whether of DEA, FDA, or state agencies, is subsection (b)(2)(B). That subsection strictly prohibits any further disclosure of names or other identifying information concerning patients, and the statutory prohibition has been buttressed by provisions of these regulations, notably § 2.54, providing safeguards and procedures to assure that the statutory prohibition is respected.

(c) In testimony and written comment on the August 22, 1974 draft of these regulations, it has been urged that access to patient identifying information by law enforcement personnel, even for the limited purposes allowed by statute and regulation, should be prohibited except pursuant to a court order obtained under 21 U.S.C. 1175(b)(2)(C). We believe that such a prohibition is beyond our power to impose.

(d) Section 307(b) of the Controlled Substances Act (21 U.S.C. 827) provides, in pertinent part, "Every * * * record required under this section * * * shall be kept and be available, for at least two years, for inspection and copying by officers or employees of the United States authorized by the Attorney General." It is a well known principle of statutory construction that amendments and repeals by implication are not favored. In *People v. Newman*, 32 N.Y.2d 379, 345 N.Y.S.2d 502, 298 N.E.2d 651 (1973), cert. denied 414 U.S. 1163, 94 S.Ct. 927, 39L. Ed. 2d 116 (1974), the United States filed *amicus* briefs with the Court of Appeals of New York and with the United States Supreme Court, arguing that section 408 of Pub. L. 92–255 (21 U.S.C. 1175) did not effect an implied amendment or repeal of the provisions of Pub. L. 91–513 (21 U.S.C. 872(c) and 42 U.S.C. 242a(a)) which confer on the Attorney General and the Secretary of Health, Education, and Welfare the power to grant the so-called research privilege discussed in § 2.24. This position was expressly adopted by the New York court. We cannot now take the inconsistent position that section 408 of Pub. L. 92–255 did indeed amend by implication section 307 of Pub. L. 91–513, particularly in the face of a contrary contemporaneous administrative interpretation by both the Special Action Office for Drug Abuse Prevention and the Department of Justice. In short, if the right of access and copying conferred on Federal agents by 21 U.S.C. 827 is to be amended to provide that it may only be exercised pursuant to a court order in the case of maintenance and detoxification programs, that is a change which must be wrought by the Congress.

(e) In the case of inspections carried out by health supervisory agencies, we think that denial of access to any documents showing patient identifying information may have a serious adverse effect on the validity of the inspection process. Even if a program keeps its own records in terms of patient-identifying numbers assigned by the program, the patient file may contain—may, indeed, be required to contain—documents signed by the patient or originating outside the program. Where signatures, names, and addresses are all obliterated, it is impossible for the inspector to check the file even for apparent internal consistency. We believe that outright forgery is and will remain a rarity, but the temptation to cover improper or inadequate documentation by "accidental misfilings" may be something else again.

(f) From a legal standpoint, the term "audit" has long comprehended the notion of external verification. In a commercial setting, this means that at least some inventory will actually be counted, at least some receivables will be verified by contacting the customers, and so on. To rule that this crucial aspect of the audit process cannot be carried out with respect to a treatment program until after the auditor goes through the procedure of obtaining a specific court order under subsection (b) (2) (C) would seem to contravene the intent of subsection (b) (2) (B).

(g) In all of this, our decisions must be illuminated by a balanced consideration of the best interests of the patient no less than a desire to foster the implementation of cherished values in society at large. If protection of the patient's right to privacy is achieved by means which seriously impair our ability to protect him from exploitation and malpractice, not to mention the diversion of funds intended for his benefit, it would be a hollow victory indeed. We believe that the procedures and safeguards which these regulations impose on the conduct of audits and evaluations will avoid that result, while affording substantial and meaningful new protection to the confidentiality of patient records.

§ 2.56 Prohibition on disclosure of patient identities from research, audit, or evaluation records—Rules.

Where the content of patient records has been disclosed pursuant to this subpart for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, information contained therein which would directly or indirectly identify any patient may not be disclosed by the recipient thereof either voluntarily or in response to any legal process whether Federal or State. This prohibition does not affect the accessibility of the original records under authority of a court order referred to in subpart E.

§ 2.56–1 Prohibition on disclosure of patient identities from research, audit, or evaluation records—Basis and purpose.

Section 2.56 restates the prohibition on further disclosure which is contained in subsection (b) (2) (B) of the authorizing legislation. The relationship of the provisions authorizing court orders to the provisions authorizing disclosure for research, audit, and evaluation, is dealt with in § 2.62.

Subpart E—Court Orders

§ 2.61 Legal effect of order—Rules.

Subsection (b) (2) (C) of the sections which authorize this part (21 U.S.C. 1175 and 42 U.S.C. 4582) empowers the courts, in appropriate circumstances, to authorize disclosures which would otherwise be prohibited by subsection (a) of those sections. Subsection (b) (2) (C) operates only as a mechanism for the relief of the duty imposed by subsection (a) and not as an affirmative grant of jurisdiction to authorize or compel disclosures prohibited or privileged by other provisions of law, whether Federal or State. An order or provision of an order based on some other authority, or a subpoena, or other appropriate legal process, is required to compel disclosure. To illustrate, if a person who maintains records subject to this part is merely requested, or is even served with a subpoena, to disclose information contained therein in a manner prohibited in the absence of a court order, he must refuse such a request unless, and until, an order is issued under subsection (b) (2) (C). Such an order would remove the prohibition, but could not, of its own force, require disclosure. If there were no subpoena or other compulsory process, or a subpoena had been issued but had expired or been quashed, the custodian of the records would have discretion as to whether to disclose the information sought unless and until disclosure were ordered by means of appropriate legal or administrative process, the authority for which would have to be found in some source other than subsection (b) (2) (C) of the sections authorizing this part.

§ 2.61–1 Legal effect of order—Basis and purpose.

(a) Section 2.61 is a restatement of the interpretative rules embodied in §§ 1401.61 and 1401.62 of the previous regulations. Both the positioning of the authority to issue court orders in S. 2097 as initially passed by the Senate (92nd Congress, 1st Session, December 2, 1971) and the explicit cross-reference in section 408(a) of Pub. L. 92–255 make clear the congressional intent that section 408(b) (2) (C) operate as a mechanism for the relief of the 408(a), strictures and not as an affirmative grant of jurisdiction to authorize disclosures prohibited by other provisions of law, whether Federal or State.

(b) The amendment made by Pub. L. 93–282 to section 333 of the Alcoholism Act (42 U.S.C. 4582) was enacted with the same language and structure as section 408 in this regard in order to make the interpretative rules set forth in § 2.61 applicable to it.

§ 2.62 Inapplicability to secondary records—Rules.

The authority which subsection (b) (2) (C) of the sections which authorize this part (21 U.S.C. 1175 and 42 U.S.C. 4582) confers on courts to issue orders authorizing the disclosure of records applies only to records referred to in subsection (a) of such sections, that is, the records maintained by treatment or research programs which have patients, and not to secondary records generated by the disclosure of the subsection (a) records to researchers, auditors, or evaluators pursuant to subsection (b) (2) (B).

§ 2.62–1 Inapplicability to secondary records—Basis and purpose.

(a) The interpretative rule set forth in § 2.62 is an essential and basic limitation on the scope of (b) (2) (C) orders. It was part of the original regulations under section 408 of Pub. L. 92–255 published November 17, 1972 (37 FR 24638), and was carried forward unchanged in the amended regulations published December 6, 1973 (38 FR 33748), the special status of which has already been noted in § 2.3. See, also, § 2.61–1.

(b) Although this rule is well supported by the history and technical structure of the legislation, the policy considerations in its favor are even more compelling. In § 2.52–1, we have discussed the urgent necessity for access, even without patient consent, to patient records on the part of qualified personnel engaged in scientific research and evaluation. Where this access includes patient identifying information, as it sometimes must if vital work is to be done, there must not be any question whatsoever about the legal inviolability of its confidential status in the hands of the researcher. Granted, there may occur rare occasions when the original records are for some reason not available, where a (b) (2) (C) order would lie as to the original records, and where there would seem to be some advantage in the administration of justice for such an order to permit disclosure of identifying information by the researcher. But compared to the damage which the mere potentiality for access does to the whole research enterprise, the advantage in terms of ability to deal with rare and anomalous cases seems almost trivial. Even in those cases, denial of access to the party seeking the information leaves him in no worse position than if the research or evaluation, which was certainly not undertaken for his benefit, had never been done at all.

(c) Where the secondary records are generated under the circumstances described in § 2.54, of course, this argument does not apply. In that situation, if preliminary examination suggests that the records may be needed for compliance or other administrative or judicial proceedings, the person conducting the audit or other examination should promptly seek the authority of a court order to copy the original records. The use of secondary records thus generated under authority of a court order would then be limited by the terms and purposes of the order, rather than subsection (b) (2) (B) of the authorizing legislation, and thus the rule set forth in § 2.62 would not apply.

§ 2.63 Limitation to objective data—Rules.

(a) *Limitation to objective data.* Except as provided in paragraph (b) of this section, the scope of an order issued pursuant to this subpart may not extend to communications by a patient to personnel of the program, but shall be limited to the facts or dates of enrollment, discharge, attendance, medication, and similar objective data, and may include only such objective data as is necessary to fulfill the purposes for which the order is issued.

(b) *Exception.* When a patient in litigation offers testimony or other evidence pertaining to the content of his communications with a program, an order under this subpart may authorize the submission of testimony or other evidence by the program or its personnel.

§ 2.63–1 Limitation to objective data.—Basis and purpose.

In the three-year period subsequent to the original enactment of 21 U.S.C. 1175, not a single occasion was reported to the Special Action Office for Drug Abuse Prevention on which an attempt was made to secure a (b)(2)(C) order authorizing the disclosure of a confidential communication by a patient to a counsellor or other member of the staff of a treatment program. In all of the comments and testimony received on the draft regulations published August 22, 1974, there was nothing to suggest any circumstances under which a court order authorizing such a disclosure would be either desirable or appropriate. Yet the mere possibility that such an order might be issued is to some a source of anxiety which impairs the effectiveness of treatment. Such an ongoing negative effect clearly outweighs the remote theoretical possibility that some peculiar circumstance might arise in which judicial authorization for such a disclosure might be sought. Accordingly, the limitation imposed by § 2.63 on the scope of (b)(2)(C) orders to preclude that possibility, and hence to eliminate its adverse influence on treatment services, appears to be a proper exercise of rulemaking power.

§ 2.64 Procedures and criteria in general—Rules.

(a) *Identity of patient.* Applications for court orders to authorize disclosure of records pertaining to a known patient shall not use the real name of the patient unless the patient consents thereto voluntarily and intelligently. In the case of an *ex parte* application initiated by the patient, the application should be instituted in the name of a fictious person, such as Jon Doe, unless the patient requests otherwise. The same procedure should be followed in the case of a separate proceeding held in conjunction with a pending criminal or civil action. Any court order should identify the patient fictitiously, and the disclosure of the patient's real name should be communicated to the program in such manner as to protect the confidentiality of the patient's identity.

(b) *Notice.* In any proceeding not otherwise provided for in this subpart, in which the patient or the program has not been made a party, each shall be given appropriate notice and an opportunity to appear in person or to file a responsive statement, deposition or other form of response consistent with local rules of procedure. The court shall give due consideration to any such statement, deposition or other response in exercising its discretion as to the existence of good cause and, if deemed necessary or desirable, consistent with local rules of procedure, it may order the program director to appear and give direct testimony.

(c) *Hearings.* All hearings and all evidence in connection therewith shall be held or taken in the judge's chambers, unless the patient requests an open hearing or the court determines that such hearing is consistent with the public interest and the proper administration of justice.

(d) *Good cause.* No order shall be issued unless the record shows that good cause exists, and in assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

(e) *Need for disclosure.* If other competent evidence or sources of information are available, the court should ordinarily deny the application.

(f) *Adverse effects.* If there is evidence that disclosure would have an adverse effect upon successful treatment or rehabilitation of the patient or would impair the effectiveness of the program, or other programs similarly situated, in the treatment or rehabilitation of other patients, the application should be denied unless the court finds that the adverse effects are outweighed by other factors.

(g) *Content of order.* Any order authorizing disclosure shall—

(1) Limit disclosure to those parts of the patient's record deemed essential to fulfill the objective for which the order was granted;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include any other appropriate measures to keep disclosure to a minimum for the protection of the patient, the physician-patient relationship and the treatment services.

(h) *Applications not otherwise provided for.* In any case not otherwise provided for in this subpart, application for an order authorizing disclosure of records to which this part applies may be made by any person who has a legally cognizable interest in obtaining such disclosure.

§ 2.64–1 Procedures and criteria in general.—Basis and purpose.

Section 2.64, in accordance with subsection (g) of the authorizing legislation, sets out procedures and criteria for the issuance of (b)(2)(C) orders in general, subject to the more specific provisions with respect to particular types of proceedings covered in the succeeding sections of this subpart.

§ 2.65 Investigation and prosecution of patients.—Rules.

(a) *Applicability.* This section applies to any application by an investigative, law enforcement, or prosecutorial agency for an order to permit disclosure of patient records for the purpose of conducting an investigation or prosecution of an individual who is, or who is believed to be, a present or former patient in a program.

(b) *Notice.* Except where an order under § 2.66 is sought in conjunction with an order under this section, any program with respect to whose records an order is sought under this section shall be notified of the application and afforded an opportunity to appear and be heard thereon.

(c) *Criteria.* A court may authorize disclosure of records pertaining to a patient for the purpose of conducting an investigation of or a prosecution for a crime of which the patient is suspected only if the court finds that all of the following criteria are met:

(1) The crime was extremely serious, such as one involving kidnapping, homicide, assault with a deadly weapon, armed robbery, rape, or other acts causing or directly threatening loss of life or serious bodily injury, or was believed to have been committed on the premises of the program or against personnel of the program.

(2) There is a reasonable likelihood that the records in question will disclose material information or evidence of subtantial value in connection with the investigation or prosecution.

(3) There is no other practicable way of obtaining the information or evidence.

(4) The actual or potential injury to the physician-patient relationship in the program affected and in other programs similarly situated, and the actual or potential harm to the ability of such programs to attract and retain patients, is outweighed by the public interest in authorizing the disclosure sought.

(d) *Scope.* Both disclosure and dissemination of any information from the records in question shall be limited under the terms of the order to assure that no information will be unnecessarily disclosed and that dissemination will be no wider than necessary. Under no circumstances may an order under this section authorize a program to turn over patient records in general, pursuant to a subpoena or otherwise, to a grand jury or a law enforcement, investigative, or prosecutorial agency.

(e) *Counsel.* Any application to which this section applies shall be denied unless the court makes an explicit finding to the effect that the program has been afforded the opportunity to be represented by counsel independent of counsel for the applicant, and in the case of any program operated by any department or agency of Federal, State, or local Government, is in fact so represented.

§ 2.65–1 Investigation and prosecution of patients—Basis and purpose.

(a) The need for objective criteria for the issuance of court orders in connection with investigation or prosecution of patients seems particularly pressing. In the absence of such criteria, the assurance of confidentiality otherwise provided for by the authorizing legislation may be felt to be of little value.

(b) It has not been found possible to frame entirely satisfactory rules for the scope of orders under § 2.65, but an illustration may be helpful. Where a witness to a crime is believed capable of identifying a suspect by appearance, and the criteria set forth in § 2.65(c) are met, and the program has photographs of its patients, the witness alone may be permitted to view the photographs, with no names attached. If the witness failed to identify any photograph as being a picture of the suspect, that would end the matter. If there was such an identification, the program would be authorized to give any information in its possession as to the suspect's identity and whereabouts to appropriate authorities.

(c) It is not the purpose of this section to substitute a mechanical formula for judicial discretion, but rather to provide criteria which define the area within which discretion is to be exercised. The reason for including all crimes committed on program premises or against program personnel is not any special solicitude for programs as opposed to other victims of crime, but is rather the result of the special difficulties which the broad definition of "records" in § 2.11(o) creates for program personnel as complaining witnesses.

(d) In regard to § 2.65(e), experience has demonstrated that independent counsel may be of crucial importance. The leading case construing 21 U.S.C. 1175, *People v. Newman*, 32 N.Y.2d 379, 345 N.Y.S.2d 502, 298 N.E.2d 651 (1973); certiorari denied, 414 U.S. 1163, 94 S.Ct. 927, 39 L. Ed.2d 116 (1974), would never have been presented to the courts but for the fact that legal counsel for Dr. Newman was furnished on a *pro bono publico* basis by a private law firm. In an entirely different case, a United States District Court appears to have issued a wholly inappropriate order under 21 U.S.C. 1175 in a case in which the treatment program involved was operated by an agency of the United States Government, and either was unrepresented, or was represented by the same attorney who represented the agency seeking the order. It is possible, of course, that the order would have been issued in any event, but it seems clear that there was no adequate presentation to the court of arguments or testimony in opposition. It is difficult to see how the purposes of subsection (b)(2)(C) of the authorizing legislation can be carried out if there is inadequate presentation of the issues to the courts which must decide them.

§ 2.66 Investigation and prosecution of programs.—Rules.

(a) *Applicability.* This section applies to any application by an administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency for an order to permit disclosure of patient records or the making of copies thereof (including patient identifying information) for the purpose of conducting an investigation or an administrative or judicial proceeding with respect to any program or any principal, agent, or employee thereof in his capacity as such.

(b) *Notice.* An application under this section may, in the discretion of the court, be granted without notice, but upon the implementation of any order so granted, the program shall be afforded an opportunity to seek the revocation or amendment of such order.

(c) *Scope.* Both disclosure and dissemination of any information from the records in question shall be limited under the terms of the order to assure that patient identities will be protected to the maximum practicable extent, and that names and other identifying characteristics of patients are expunged from any documents placed in any public record. No information obtained pursuant to an order under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65.

§ 2.66–1 Investigation and prosecution of programs—Basis and purpose.

The principal purpose of § 2.66 is to enable a regulatory agency whose inspection or other source of information has disclosed a need for follow-up, or which has been refused access to patient records, to obtain the necessary authorization for access and copying. There may also be rare instances, such as those involving financial fraud, tax evasion, or other offenses where access by other investigative agencies is necessary, subject to the requirements and protections of this part.

§ 2.67 Undercover agents and informants—Rules.

(a) *Applicability.* This section applies to any application by an administrative, regulatory, supervisory, investigative, or law enforcement agency for an order to permit such agency to have an undercover agent or informant in a program under circumstances which would otherwise be prohibited under § 2.19.

(b) *Notice.* An order under this section may be granted without notice where the criminal conduct for the investigation of which it is granted is believed to be carried on by the program director or by any employee or agent of the program with the knowledge of the program director or under such circumstances that in the exercise of reasonable care the program director should know of such conduct. Under any other circumstances, an order under this section may be granted only after the program director has been afforded notice and opportunity for hearing.

(c) *Criteria.* An order under this section may be granted only where there is reason to believe that a program or any principal, agent, or employee thereof is engaged in serious criminal misconduct, and that other means of securing evidence of such criminal misconduct are not available or would not be effective.

(d) *Scope.* An order granted pursuant to this section may authorize the use by the applicant of an undercover agent or informant, either as a patient or as an employee, of the program in question.

(e) *Time periods.* An order under this section may not authorize the use of an undercover agent for an initial period exceeding 60 days. At any time prior to the expiration of such 60-day period, the applicant may apply for an order extending such period for an additional period not to exceed 60 days, but in no event may the use of an undercover agent in any program be authorized for more than 180 days in any period of 12 consecutive months.

(f) *Duty of agent.* Except to the extent expressly authorized in an order under this section, which shall be limited to disclosure of information directly related to the purpose for which the order is granted, an undercover agent or informant shall for the purposes of this part be deemed an agent of the program within which he is acting as such, and as such shall be subject to all of the prohibitions of this part applicable to disclosures of any information which he may acquire.

§ 2.67–1 Undercover agents and informants—Basis and purpose.

The legal rationale underlying this section has been set forth in § 2.19–1. It is expected that this section will find its principal and perhaps its exclusive application in the area of drug law enforcement. Experience has demonstrated that medical personnel, no matter how credentialed, can engage in the illicit sale of drugs on a large scale, and that the use of undercover agents and informants is normally the only effective means of securing evidence sufficient to support a successful prosecution.

[FR Doc.75-17169 Filed 6-27-75;9:38 am]

Title 21—Food and Drugs

CHAPTER III—SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION

PART 1401—CONFIDENTIALITY OF DRUG ABUSE PATIENT RECORDS

Revocation of Part

On May 9, 1975, there was published in the FEDERAL REGISTER (40 FR 20542) a notice of proposed rulemaking proposing the revocation of Part 1401 of Title 21 of the Code of Federal Regulations by reason of the proposed incorporation of its subject matter in a new Part 2 of Title 42 of the Code of Federal Regulations.

Interested persons were invited to submit written comments, views, or arguments with respect to the proposed revocation, within 30 days of the date of publication of that notice. None were received, except to the extent that they were implicit in those submitted on the proposed new Part 2 of Title 42 of the Code of Federal Regulations, which were duly considered.

Accordingly, pursuant to the authority of section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended by Pub. L. 93-282 (21 U.S.C. 1175), and under the authority delegated to the General Counsel (39 FR 17901, May 21, 1974), Part 1401 of Title 21 of the Code of Federal Regulations is revoked, effective August 1, 1975.

Dated: June 25, 1975.

GRASTY CREWS, II,
General Counsel, Special Action Office for Drug Abuse Prevention.

[FR Doc.75-17170 Filed 6-27-75;9:38 am]

MODULE 7: COMMUNITY ORGANIZATION

FOCUS

In Module 7 participants have an opportunity to consider aspects of working with organizations to identify and approach possible resources. Each participant will also have an opportunity to develop an action plan for change in his or her own program that is based on the principles for community organization.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Name three aspects of physical staging that can be used advantageously
- Cite two positive uses of language adaption
- Cite two negative aspects of poor language use
- Identify procedures for working with boards and committees that increase the probability for successful negotiations
- State the major qualification of a community organizer
- Develop an action plan for change in their programs
- Describe two considerations in approaching potential resources to better insure cooperation
- Explain the importance of using resources that are available, accessible, and acceptable to the client

MODULE 7: COMMUNITY ORGANIZATION

PRESENTATION: COMMUNITY ORGANIZATION

Use the space below to take notes during this presentation on community resources and organization, as outlined in the resource papers, "Basic Principles of Community Change," "Win/Lose Situations," and "Decision-Making."

ACTIVITY: NEGOTIATIONS LABORATORY

Goal

This activity is designed to promote an understanding of staging and negotiating.

Description

Group members act out situations involving staging and negotiating. During each role play, take careful notes. Discuss each role play before preceding to the next.

Comments

ACTIVITY: INDIVIDUAL PROGRAM ACTION PLAN

Goal

This activity is designed to help each participant develop an action plan for his program.

Description

Write an action plan for change to be implemented in your program. Because the results of various steps in the plan are not predictable, develop several alternative possibilities, specifying: (1) who will perform the designated tasks, (2) who will be dealt with outside the core group, (3) the issues that may be involved, and (4) the pitfalls that may be encountered, with contingency plans for dealing with these.

Comments

BASIC PRINCIPLES OF COMMUNITY CHANGE

Stan DeKemper

Division of Addiction Services
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BASIC PRINCIPLES OF COMMUNITY CHANGE

A critical factor in the successful rehabilitation of a substance abusing client is the degree to which a counselor's efforts are complimented by his program and by his community. Often counselors spend significant portions of their work time attempting to offset a program structure or program policies which hinder the therapeutic progress of a client. Or perhaps the resources in the community are fragmented and don't work together. If the resources in the community are fragmented, then the counselor is forced to "do it all" himself or become quite frustrated. Usually, the counselor becomes frustrated and allocates considerable blocks of time to talking about program reporting requirements, the lack of community acceptance or support, and his program director's or board's insensitivity to client needs.

Commonplace is the counselor who focuses only on "counseling" his client and not on maximizing his own effectiveness by mobilizing community resources, altering program design and developing community awareness of his client's plight. "Ain't it awful" is this counselor's battle cry. The mark of an effective counselor is his success at being a change agent within his program and community as well as with a client.

How does a counselor go about influencing his program and/or community to be supportive of his work? To increase the probability of change occuring within a program or a community, a counselor needs to utilize the concepts of community change and of negotiation.

COMMUNITY CHANGE

In order to understand the process of community change, a brief review of the historical development of community organizing is helpful. The labor union movements in the 1930's were the beginning of a wave of social change which dominated the United States until 1970. The labor movement was followed by the civil rights push for blacks, for women, for gays and for other minority groups. All these movements involved uniting a group of people around a common issue so that the issue could be resolved. Characteristic of these organizing efforts was a win-lose philosophy. This win-lose approach is epitomized by the tactics and language used by the black movement of the '50's and '60's. Sit-ins, protest marches, the black power clenched fist demands and television coverage were some of the tactics used while the language of the movement was polarized and actually divided people. "If you're not part of the solution, you're part of the problem." was a popular phrase and is symbolic of the polarized, right-wrong morality which characterized most of win-lose organizing. Visibility for such organizing efforts was generally high with leaders such as Dr. Martin Luther King seen in public places, on T.V., on the radio or on the frong page of the newspapers. Such visibility combined with polarized language and tactics created an atmosphere of attacks and hostility. While win-lose organizing won battles, it often lost the war. Attacking the mayor of city publically never endeared the mayor to the group who attacked him. Sure, the community group may have gotten their demand met for re-paving their street but the mayor would not give them cooperation in the future unless they overpowered him again, which is less likely the second time around.

Below is a chart which compares the concepts of win-lose organizing and those of win-win organizing:

APPROACHES TO COMMUNITY ORGANIZING

Win-Lose		Win-Win
Power concedes nothing	- Philosophy -	Appeal to individual interests
Moral Rights	- Focus -	Satisfy needs
Polarized	- Language -	common
Us	- Recognition-	others
high	- Visibility -	hidden
Attack, hostility	- Atmosphere -	warm, sharing
Negatively defined	- Future -	open

Since the 60's, community organizing efforts have generally begun to move from a win-lose posture to that of win-win. Although there have been enormous "victories" through using win-lose approaches in organizing, win-lose is now viewed as a last resort because of its divisive power.

In win-win approach, the organizer appeals to the self-interests of everyone involved. He appeals to the ego needs of management as well as line staff. The organizer focuses on satisfying needs of the community or agency. A win-win organizer focuses on needs which the people agree on rather than over what they disagree. If the approval of the school superintendent is needed for implementation of a substance abuse education program, you would focus on your agreement of the need for education rather than your disagreement over whether drug and alcohol addiction are diseases or merely symptomatic behavior. The language used in such an encounter would be language which is acceptable to the superintendent. If he does not like the word "sensitivity," the win-win organizer would use words like "identifying individual strengths and weaknesses" so that the superintendent is not alienated.

When the T.V. cameras roll, it is the superintendent who is filmed, not the organizer. The win-win organizer has low visibility. The most important characterstic of a win-win organizer is that when the job is done, everybody else involved thinks they did it. The atmosphere which surrounds such organizing is warm and everyone involved participates in the decision making. The future of such an organizer is always open. The school superintendent will call on the organizer again when he has a need because the organizer makes things happen while the superintendent gets the recognition.

In implementing either a win-win or a win-lose approach to community organizing, an organizer should utilize a systematic methodology to achieve the change desired. Often an organizer will become so excited in the heat of the moment, that strategy and action supercede the preparation and clear-headed analysis vital for any successful change effort. How often have you witnessed yourself or a co-worker run to the program director or school principal with change in mind only to be defused with "thats the way things are" or "they really arent' that bad" response.

To realistically facilitate change within an agency or community, it is essential that an organizer systematically follow a methodology. The following six-step organizing procedure is a process that focuses on people as well as facts and problem solutions.

Define Community

A community is a group of people which share some common characterstics. A community may be religious (Jewish) geographical (Northside Indianapolis), racial (black) or an agency (the South Bend Detoxification Program). It is imperative to define specifically which community is the target population for organizing change.

Assess Community

A thorough assessment should be made of the community targeted for change. The assessment should give the organizer a wholistic picture of the community: how the members of the community view their community as well as what is actually there. Many times there will be significant discrepancies prevent the community from utilizing its resources to solve its problems. Listed below are elements of a community which should be explored during the assessment process.

Definition of Elements

History. History may be thought of as the "selective recording and interpretation of past events." That is, you never learn about all of the previous activities in the life of a country or community; the causes and effects of past events are usually explained in one way or another.

In reviewing the history of the community, we are concerned with:

(1) its official and more or less "objective" history as it may be given in public documents, etc., and
(2) its traditional or folk history as recounted by its residents.

A preliminary study of the history of the community provides:

-background information needed to understand its present position and problems.
-a widely acceptable means to show your respect for its people and their way of life.
-an opportunity to meet a number of its key residents.
-many insights into conflicting values, factions, etc.

Space Relations. Through this element we look at:

(1) the internal relations within the community, its geographic area, and the disposition of its people, industry, social activities, etc.;
(2) the external relations of the community with other communities in the vicinity and with the regional and national capitals,

including the means of communication and transportation and the distances and times involved for each;
(3) the number and kinds of links that exist between this community and others through trade, marriage etc.

Resources. The resources of a community are any aspects of its total environment which its people may use to meet their individual and shared needs. Such resources include the services available from government and private agencies. In assessing resources, the following subdivisions may be useful:

-- human -- the number of people and their capabilities, with allowances made for age, disease, malnutrition, etc.;
-- man-made -- such items as roads, communication media, etc.;
-- natural -- land, water, minerals, forests, sources of energy, etc.

Technology. Technology consists of the tools, skills, and techniques used by people ot exploit their environment. Through this element we examine the methods used by people to make a living from their resources, the kinds of know-how they employ to solve problems, and the ways in which they adapt to their circumstances. (Technology is thus linked with the available resources, knowledge and beliefs, the goals and norms of the people, and their values and sentiments.)

Knowledge and Beliefs. This element covers what is known and thought about the world, and life in it, and is thus related to technology, the use of resources and goals.

In belief there is an aspect of personal conviction which is absent from mere knowledge. It is therefore easier to change knowledge, on the whole, than to affect belief. On the other hand, a program linked to people's beliefs has a firmer foundation than one which is based upon items of information which they know, but do not particularly care about. Beliefs are linked with values and sentiments.

Values and Sentiments. *Values* are essentially "ideals of the desirable" which are held by individuals; many values are shared by most of the people in the community and thus form the basis for predictable patterns of behavior.

Sentiments consist largely of what people feel about certain issues. Both values and sentiments are very resistant to change. Often they form the basis for community-wide action, whether planned or unplanned. Despite the difficulties, it is crucial to identify the principal values and sentiments in the community since they form the foundation of goals, norms, social rank, sanctions, and other elements.

Goals and Felt Needs. These are the specific and concrete targets which people set for themselves; they are clearly related to the people's values and sentiments and also to their knowledge and beliefs. As with those elements, some goals will be shared by most of the people in the community, others will be limited to certain subgroups, and others will be specific to individuals. A widely shared goal may become the focus for an early development project.

Goals may also be thought of as felt needs. Of the many needs which may be observed in a community, people will be aware of some of them; these are their felt needs, in contrast to other needs which they do not recognize.

Norms. Norms are the standards of what is right or wrong, good or bad, appropriate or inappropriate in social life in the community. They form the "rules of the game" which indicate acceptable standards of conduct for every social situation. Norms are apecific recommendations for behavior derived, like goals, from the values and sentiments of the people. Norms are enforced by various forms of social pressure (see Sanctions) in the community.

Positions and Roles. The positions in a community range from formally elected offices through to the informal position of "best friend." The set of behavior patterns associated with each position is termed a *role*. Usually, an individual holds a number of positions, (i.e., one man may be a town councilor, a farmer, a husband, a father and a son, to name just a few). His behavior in any given situation depends upon which position he sees himself in, and what cluster of behaviors he associates with that position.

To give an example, you may be baffled when a man agrees with you on one occasion and then disagrees later. In the first case, he may have agreed with you in his capacity as village leader, but in the second he spoke as a highly conservative head of his family. If you were assigned to a village by a government health agency, you might be rejected initially by the villagers as a potential tax assessor. But if you then took on some more acceptable positions (friend of youth, musician, gardener) and acted out these roles effectively, you and your real work might later bacome widely accepted.

Power, Leadership, and Influence. *Power* describes the ability of one person to control others. *Leadership* involves the ability to help a group to make decisions and to act on them; it may include organizing people formally or informally. Remember that a leader is one who has followers -- not all who act and sound like leaders actually have followers. Leadership capacity is indicated by the number and stability of a leader's following. Most leaders lead from in front; many other effective leaders prefer to lead from behind, quietly and almost unnoticed -- don't overlook them! *Influence* is the ability to affect the behavior of others, often without their being fully aware of it.

Note that while some people possess these capacities in most spheres of community life, others are effective in only one area; e.g., a man may be a power figure, a leader or influential in matters of agriculture but not in social or political life.

Social Rank. Social rank describes the standing that a person or group has in the community; it may depend largely on one's family and inherited characteristics, or it may rest upon the individual's personal achievements. The factors which determine who "rates" depend a good deal on the values which predominate in the pattern considered.

Sanctions. These are the rewards and punishments which induce an individual to retain the goals and norms of the group. They help to assure the preservation of the group and its way of life by encouraging support for its values and sentiments, positions and roles.

Develop Core Group

Once the community 4as been assessed, a core group of community members should be formed who have interest in change and, hopefully, some influence in their community. These members should have been identified during the assessment. The organizer's task during this step is to develop healthy win-win dynamics among this group.

Set Priorities

From the assessment a huge amount of data has been generated. The organizer's function during this step is to aide core group members in analyzing the assessment data and determining the priorities for change. Care should be taken to set prioriteis which are attainable.

Develop Strategy

A plan of action or strategy should be developed by the core group which delineates the priority objectives, what tasks will be necessary to achieve the objectives, a timetable and an assignment of responsibilities for task accomplishment to individual group members. Included in the strategy development may be practice for core group members in how they will approach other members of the community during negotiations.

Action-Reflection

After a strategy has been developed to accomplish priority objectives, the strategy is then executed. It is essential that after every major task is carried out, that task should be reflected upon. Often a core group will need to change their strategy based upon outcomes

If these six steps of community are adhered to and if the organizer is aware of his stance regarding a win-win posture, the probability of his influencing meaningful change will be greatly enhanced.

NEGOTIATION

One aspect of community organizing which deserves special attention is the art of negotiation. Negotiation is generally associated with win-win approach to change. The term itself implies a solution to a porblem which is mutually satisfying to all parties involved in the problem.

The primary goal of a negotiator should be to achieve his desired outcome through a consensus decision of the people involved in the negotiation. A successful negotiator needs to have all people involved in the negotiations invested in the outcome in order to prevent sabatage at a later date in his relationship with these people.

One of the most important aspects of fruitful negotiation is the effective self-presentation of the negotiator. There are three basic areas of concern for effective self-presentation during negotiations.

Preparation

A negotiator should always diagnose the problem or conflict which he desires to resolve. He should analyze the forces which push for change and those which restrain change. An understanding of these forces will aid in visualizing what are the assets for change and what are the liabilities restraining change.

Once these forces are understood, the negotiator can identify what areas of agreement to highlight during negotiations. A written document should always be prepared prior to negotiation which stress such areas of agreement and contain the outcomes desired by the negotiator. Such a document should be brief or at least contain a summary paper.

Win-Win Philosophy

In approaching negotiating, an organizer should be in a head set of wanting to listen to and satisfy the interests and needs of the other parties involved.

Staging

One of the most crucial issues of negotiation is the physical presentation of self during negotiations. Seating arrangements, body postures and body movements are elements of staging which communicate very powerful messages to participants of a negotiating process. Sophisticated negotiators often spend enormous blocks fo time deciding who will sit where. The Paris Peace talks on Vietnam during the early 1970's spent months negotiating over who would sit where around what kind of table. Most people who you will negotiate with will not be that sophisticated. In fact, if you understand the dynamics of staging and are confident, you should be able to control the staging process.

Below are some general guidelines for staging negotiations for a one to one basis and for one to group staging.

STAGING
(1-1)

1. Come in close-
   shake hands - smile -
   or touch - smile -

2. Back off and when possible choose your site carefully
   Take a
   - (a) center position
   - (b) high position
   - (c) front position

3. When site is forced
   - (a) rearrange chair before you sit down - (harder with a sofa) ESTABLISH YOUR OWN SPACE
   - (b) SIT BACK - you are comfortable

4. Tell 'em what you're gonna say
   SAY IT
   Tell 'em you said it

5. Terminate quickly - slightly abruptly but not hastily
   Stand Up - say it was good talking to you

   LEAVE - DON'T LINGER - DO NOT ALLOW THIS KIND OF INCOUTER TO SHIFT TO AN EMOTIONAL - OR SOCIAL INTERACTION AT ITS TERMINATION - SO GET OUT WHILE YOU'RE AHEAD OR BEHIND.

STAGING
(Groups)

1. Walk into room calmly and purposefully

2. Cross the front of the room

3. Choose site carefully -
   again - front
   center
   high

4. SIT BACK

5. Smile to those around you - YOU ARE COMFORTABLE!

In concluding, I would encourage you to review the concepts of community/program change and of negotiation presented in this paper and apply them to your own situation and needs.

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I would also like to express appreciation to Tom Oaks, V.C. League, and Joel Warner for their inspiration and ideas.

WIN/LOSE SITUATIONS*

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* Reprinted from *The 1973 Annual Handbook for Group Facilitators*, J. William Pfeiffer and John E. Jones, Editors. La Jolla, California: University Associates Publishers, Inc. 1973.

WIN/LOSE SITUATIONS

Win/lose situations pervade our culture. In the law courts we use the adversary system. Political parties strive to win elections and to win points in legislatures. Debates are common at schools, universities, and in the media. The put-down is generally regarded as wit. Competing with and defeating an opponent is the most widely publicized aspect of a good deal of our sports and recreation.

The language of business, politics, and even education is dotted with win/lose terms. One "wins" a promotion, "beats" the competition, buys a lubricant to obtain "the racer's edge" for his auto. Students strive to "top the class" or "outsmart" the teacher. Although we do recognize cooperative effort and collaboration, it seems that we tend to emphasize "healthy" competition.

In an environment that seems to stress winning, it is no wonder that competitive behavior persists where it is not appropriate. Imagine a typical committee meeting to decide on a suitable program for a club. Members interrupt each other to introduce their own ideas. Proposals are made which other members do not even acknowledge. Partnership and even power blocs are formed to support one program against proponents of another. When members of such a committee are enabled to analyze the operation of the group, they commonly agree that they were not listening to each other because they were thinking of ways to state a case or to counter the proposal of someone else. They were interrupting to get a point out before the speaker clinched the sale of his idea. In these ways they were acting as competing individuals rather than a collaborating group. They had started to reach the best decision regarding the program, but had slipped into a win/lose contest. Very often the original purpose is completely overshadowed by the struggle to win. This is a common failing of committees.

Group meetings are not the only sphere in which win/lose can arise. Visualize a consultant discussing a client's problem. For any of a number of reasons, the client may perceive his helpful suggestions not as the consultant intends but as criticism of the client's methods, or whatever. As a result the client might also feel that he was in competition with the consultant. The contest would revolve around whose methods were more effective or who could do the job better. Instead of listening to the recommendations, the client would be trying to shoot them down. For his part, the consultant would be concentrating on defending his expertise. When a consultant and client are locked in a win/lose match, the chances are very small that the consultant's advice will be used.

Win/lose contests can also develop in an organization. Individuals may strive for dominant position. Battles can rage discreetly, and otherwise, between departments. For example, a planning department might develop a new assembly procedure. When it is introduced to the assembly department, the workers might resent it and lock horns with planners. It is easy to interpret the situation in win/lose terms. The planners are showing that they know more and can design a procedure better than the men on the job. If the new procedure works well, the planners "win." On the other hand, if the innovation does not improve production, the planners "lose," and, in a sense, the assemblers "win" because their normal operation proved superior. Seen in this light, it should be expected that the workers will not be committed to giving the innovation a fair trial. In extreme cases, they may even sabotage it "to show those theoretical snobs in Planning." In fact all efforts to plan for others are plagued by win/lose traps. In some companies and institutions internal win/lose rivalries absorb more effort than the main production or service.

POTENTIAL RESULTS OF WIN/LOSE

Although there are obviously some instances where win/lose is a positive factor, it is generally destructive. Win/lose is too often poison to interpersonal relations and organizational effectiveness. Suppose a husband loses an argument with his wife so that they go dancing instead of to a horse race. He can retaliate by being sullen or obnoxious. He has turned a win/lose situation into an ordeal where both partners are miserable. Often win/lose "victories" become losses for both parties. This has been termed a "lose/lose" result.

Some of the negative results of win/lose have been shown in the examples already given. Here is a list of fourteen problems which may arise from win/lose confrontations. They are not in any particular order, nor are they comprehensive.

Win/lose may:

1. divert time and energy from the main issues
2. delay decisions
3. create deadlocks
4. drive unaggressive committee members to the sidelines
5. interfere with listening
6. obstruct exploration of more alternatives
7. decrease or destroy sensitivity
8. cause members to drop out or resign from committees
9. arouse anger that disrupts a meeting
10. interfere with empathy
11. leave losers resentful
12. incline underdogs to sabotage
13. provoke personal abuse
14. cause defensiveness

ADJUSTING WIN/LOSE

Since win/lose events will undoubtedly be experienced by us often in the course of time, it is important to know how to cope with them. Since the predominant trend of win/lose contests is toward lose/lose outcomes, it becomes a matter of redirecting them toward "win/win" results. In a "win/win" result everyone comes out on top.

It is extremely difficult for one person alone to reorient a win/lose. You are likely to be treated as a third party in the scrap, or you may have both adversaries turn on you. Although it would be ideal to have all parties committed to avoid win/lose, the efforts of a significant segment of a group can usually be effective. In a one-to-one conflict, one of the parties can often turn off a contest. It takes two to fight. The more persons in a win/lose situation who recognize the dangers in such a struggle and want to adjust the situation, the more likely they will succeed. Supposing such a subgroup exists in a committee, what can they do to help?

Some Means of Adjustment

1. Have clear goals, understood and agreed upon. Use the goals to test whether issues are relevant or not.

2. Be on the lookout for win/lose. It can develop subtly. If you feel under attack, or feel yourself lining up support, you are likely in a win/lose.

3. Listen empathetically to others. Stop yourself from working on counter-arguments while another person is speaking. Take the risk of being persuaded. Try the other person's reasoning on for size.

4. Avoid absolute statements that leave no room for modification. "I think this is the way..." is better than "This is THE ONLY way..."

5. If you are planning for others, provide some means for their involvement. The doers should feel that they can have influence on decisions that affect them.

6. Try to make decisions by consensus rather than by victory of the majority.

7. Test to see that trade-offs and compromises are truly accepted by all.

8. Draw a continuum line and have members place themselves on it regarding the issue. It often occurs that the different "sides" are not far apart.

9. Be alert to selling or winning strategies in others, and avoid using them yourself. "Any intelligent person can see the advantages..." would be a danger signal.

Again this list is not exhaustive, but may provide a beginning toward more productive relationships. The key idea in adjusting win/lose is to strive for what is *best for all* rather than trying to *get your way*.

DECISION MAKING

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DECISION MAKING

Every group, to achieve its goal, is constantly involved in making decisions--little decisions, easy decisions, hard decisions, right decisions, wrong decisions, but always decisions, decisions, decisions.

Decision-making is thus a continuing pattern of relationships among members of a group, a pattern over which every individual member has significant influence. It is amazing the effect a bit of information here, a loud objection there, an expression of approval or hostility, envy or admiration, contempt or condescension can have on an impending decision.

So there is little wonder that group after group has difficulty making decisions. Some become paralyzed when confronted with a decision; some argue interminably over a minor point; others rush into a vote, only to reverse their decision later on or to fail in carrying it out; others appoint a committee or look for a saviour (the chairman) to save them from having to decide.

DIFFICULTIES IN DECISION-MAKING

Most of the difficulties encountered by the group in making decisions center around one or another of the following factors.

1. *Fear of Consequences*
   In some groups the *possible outcome* of an impending decision may bring divisions and disagreements. Frank acknowledgement of these fears often suggests how they can be dealt with effectively.

2. *Conflicting Loyalties*
   Multiple membership in a number of groups frequently leads to *divided loyalties* among group members. An atmosphere in which it is possible for these conflicts to be brought out into the open without threat to the individual is a great help in their resolution.

3. *Interpersonal Conflict*
   In groups of any size personal differences occur which provoke feelings of affection or of antipathy among members and which inhibit sound decision-making. Often another member who is not involved in the interpersonal conflict can bring the real problem into bolder relief.

4. *Methodological Blundering*
   A group may be so *bound by rigid procedures* that there is little chance for free expression of differences. Or a group may allow itself to *substitute personal opinion for adequate data*. Or a group may approach the decision-making process without testing for consensus.

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5. *Inadequate Leadership*
   A designated leader falls short of his responsibilities when he restricts the expression of opinion or discussion of issues, when he fails to provide assistance in selecting appropriate methods for decision-making and when he is insensitive to the factors causing difficulty - the motivations and standards of his group.

AREAS OF DECISION-MAKING

Six basic problem areas in the movement of a group toward its goal can be identified. Of course, no group moves directly through the six problem areas in a given order.

1. *Problem Area #1:*
   (What is our situation?)
   Who are we? Where are we? What is our common ground? What are the limits within which we must work? Who or what brought us together? Until a group recognizes its actual present situation, by gathering the data about that situation, any attempt to suggest goals is premature.

2. *Problem Area #2:*
   (What is our destination?)
   Where do we want to go? What choices are open to us? Until there is general *agreement on the goal*, the group will not move effectively. Members of a group who have not accepted the goal or who have had little voice in choosing it tend to be self-oriented. The greater the share all members have in choosing the goal of a group, the greater will be their willingness to subordinate their immediate personal interests to the common interests of the group. The settling of a goal is also necessarily tentative and must be reexamined from time to time in order to test its adequacy.

3. *Problem Area #3:*
   (How do we get there?)
   What procedures are called for? What resources are needed? Members become more involved in the functions of *initiating*, *clarifying*, *expediting*, and *testing* for consensus as a group goes about determining the best ways and means, routes and methods, necessary to get underway.

4. *Problem Area #4:*
   (How free are we to move?)
   If a group is to be creative, individuals must be free to act, to offer insights, to test ideas, to make contributions, to share the leadership without fear of inadequacy. Such functions as *encouraging*, *harmonizing*, and *supporting*

are needed to maintain an atmosphere of freedom.

5. *Problem Area #5*:
   (Where are we now?)
   Where are we in the process of settling all the other problems? Are we going in the right direction? How far have we gotten? Do we know where we are? Do we need to change our goal or our procedure? Is everyone still on board? *From time to time a group must make a progress report to itself.* Many a group has failed to reach its goal because it assumed everyone knew where the group was when actually confusion reigned.

6. *Problem Area #6*:
   (Where have we arrived?)
   Have we reached our goal? Where are we finally in terms of our achievement? It may not be the original goal, but is it satisfactory? A group sees its goal through the eyes of its members and their need to arrive at some goal.

CATEGORIES OF DECISIONS

In moving toward its goal and in solving its problems, a group makes countless decisions, usually in a variety of ways.

1. *Plops*
   A decision *suggested* by an individual to which there is *no response.* Plopping often occurs in a new group confronted by a complexity of problems, in a group where a number of the members have fairly equal status, when a member is overly aggressive, when a member has difficulty in articulating his suggestions.

2. *Self-authorized Decision*
   A decision by an individual who assumes authority to do so. When such a decision is proposed, the group as a whole often finds it easier to accept than reject, even though some individuals may not be in agreement. The *decision* is *thus by default.*

3. *Hand Clasping*
   A decision made by two members of the group joining forces. Such a decision emerges so suddenly that it catches the other members of the group off guard and at the same time presents them with another problem (how to deal with the two people at the same time).

4. *Topic-jumping*
A *decision cut short* by the inappropriate intrusion of another topic. Topic jumping confuses the issue confronting the group and thus changes the nature of the decision.

5. *The Clique*
A decision agreed upon in advance by several members of the group. Cliques are present in almost every group and their prearranged decision may be very good. But the effect of collusion is to *destroy group cohesiveness* and a sense of trust among group members.

6. *Majority Rule*
A decision made by some form of voting. The traditional procedure of taking a vote often seems to be the only way in which to reach a decision under the given circumstances. *Nonetheless the minority may remain against* the decision despite the vote and *therefore not likely to act on it.*

7. *Does Anyone Disagree?*
A decision made by pressure not to disagree. When confronted by such a question, several persons who really disagree strongly or who have not had opportunity to express their opinion on the issue, may show real *reluctance to voice opposition with no apparent support.*

8. *We All Agree, Don't We?*
A decision made by pressure to agree. Again, as when under pressure, persons who really disagree or who have not had an opportunity to express their opinion would probably be reluctant to voice opposition alone.

9. *Unanimity*
A decision made by an overt and unanimous consent. The pressure to conform may be strong enough to win apparent 100% agreement. But even a majority of the members may inwardly disagree and may consequently fail to act in support of the decision.

10. *Consensus*
A decision made after allowing all aspects of the issue, both positive and negative, to be put forth to the degree that everyone openly agrees it is probably the best decision. Dissenters, once they have been clearly heard, will usually go along with a decision and act

upon it with commitment, at least to the point of provision for later assessment.

STEPS IN DECISION-MAKING

Effective decision-making by a group on the basis of consensus is both realistic and possible. But it is not easy. There are five basic steps which a group can take in arriving at a decision with some assurance that it represents the mind of *the group as a whole and that it will be acted upon.* It is well also to be aware of what might help a particular step, of what might block it, and of what might cause its omission.

1. *Defining the Problem*
   The process of defining the problem, *sharpening the focus* so that the issue is clear, internalizing its various *implications*, clarifying it and elaborating on it.
   a. *omission:* a standing committee that is reappointed year after year but that never reviews its purpose.
   b. *blocks:* the assumption that the problem is clear: over-abstraction of the problem; the assumption that the problem is relevant.
   c. *helps:* a problem census; small groups; general discussion.

2. *Suggesting Alternative Solutions*
   The process of getting ideas on the various *alternative* solutions to the problem from all *members.*
   a. *ommission:* a chairman who limits a group to working on the implications of a solution he has already decided upon.
   b. *blocks:* lack of data; lack of experience; group size; member threat; overformality; inadequate maintenance functions; polarizing on a particular solution.
   c. *helps:* brainstorming; additional data; subgroup work; a climate of freedom; periods of silence.

3. *Testing the Alternatives*
   The process of examining the alternatives in the light of all available data, percious experience, possible consequences, relevance to the problem, and members' attitudes.
   a. *omission:* the prestige or influence of the chairman or of some other member which prevents the group

from putting his alternative under real scrutiny.

b. *blocks:* lack of data; premature voting; overprotection of ideas by individual members; inadequate maintenance function.

c. *helps:* provisional try attitude, collaborative rather than competitive; group seeking to make each alternative really attractive.

4. *Choosing Among Alternatives*

The process of reaching a decision by choosing one of the alternatives, or a combination of alternatives, that will provide a solution to the problem defined.

a. *omission:* a committee that goes on and on and on - exploring the ifs, ands, and buts, ad infinitum - but never arrives at a decision.

b. *blocks:* inadequate testing; lack of clarity regarding the problem; premature voting; no testing for consensus; identification of ideas with persons.

c. *helps:* expression of feelings by all members; maintenance of an agenda for future reference; summarizing of discussion; testing for consensus.

5. *Planning For Action*

The process of *making detailed plans for carrying out the decision* by examining the implications of the choice and testing the relevance of proposed action. It should be noted that the planning step sometimes results in re-thinking the decision and *returning to one or another prior step* in the decision-making process.

a. *omission:* failure to assign responsibility for implementation of the decision once it has been made.

b. *blocks:* failure to reach consensus; failure to explore adequately the implications of proposed action; assigment of total responsibility for implementation to one person.

c. *helps:* feedback; observer reports; evaluation; post meeting reaction reports; review of data; climate of freedom.

CONDITIONS RELEVANT TO GROUP DECISION-MAKING

There are many instances where, due to the pressure of time, the type of decision, or the area of responsibility, an individual and not a group may most appropriately make a decision. There are, however, certain conditions that make decision-making by a group the most appropriate means of solving a particular problem:

- when *various points of view* and opinions are needed.
- when the *group is directly affected* by the decision.
- when the *group must carry out the decision.*
- when the group has learned to work effectively together.
- when the leadership functions are shared.
- when decision-making procedures appropriate to the problem are used.

FACTORS WHICH FACILITATE GROUP DECISION-MAKING

There are certain specific factors that affect any group situation and that serve especially to improve the decision-making process:

- a clear definition of the problem
- a clear understanding of who has *what degree of responsibility* for the decision
- effective means of producing and communicating ideas
- an appropriate size of the group for decision-making
- effective means of testing alternative solutions
- effective means of implementing the decision
- commitment of the designated leader to the group decision-making process
- agreement on the decision-making procedure prior to deliberation on the issue.

MODULE 8: CLOSURE

FOCUS

In Module 8 the training course is brought into perspective. A contextual review of the design and of the considerations leading to that design will help participants understand the process they have experienced.

LEARNING OBJECTIVES

At the end of this module, participants will be able to:

- Demonstrate an increase in knowledge on addictions and counseling in terms of the four cognitive training objectives for Unit C (See Training Objectives, Unit C, page 3)
- Demonstrate a statistically significant attitudinal change in two attitudes specified in the Training Objectives, Unit C
- Show that they have assessed client intake data, written a treatment plan, and selected modes of treatment
- Show that they have developed an action plan for change in their program or community
- Describe the rationale of the training process for the Individual Counseling Skills Training Course
- Name two ways that the design of the course allowed their individual needs to be met

MODULE 8: CLOSURE

POSTTEST AND EVALUATION

The posttest is designed to measure group change rather than individual performance and to help the staff know if their training goals have been accomplished.

After completing the posttest, evaluate the training by responding to the following questions and statements.

1. What did you find least helpful?
2. What did you find most helpful?
3. Write one postive and one negative feedback statement to each member of the staff.
4. Do you have any other comment about the training?

PRESENTATION AND DISCUSSION: REVIEW OF THE COURSE

This presentation will include a review of the course design and the considerations leading to that design. *Following the presentation you will be able to discuss the rationale of the training process for individual counseling skills and how the training met individual needs. Space for notes is provided below.*

ACTIVITY: GROUP CLOSURE

Goal

This activity is designed to provide emotional closure to the training experience.

Description

Share your feelings and thoughts about the group and about the experiences you have had together. You may also comment on what you have learned and how this will affect your work.

Comments

Use the space below for any additional notes.

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